CCME

2017 External Quality Review

ABSOLUTE TOTAL CARE

Submitted: March 28, 2018

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. The purpose of this review was to determine the level of performance demonstrated by Absolute Total Care (ATC) since the 2016 Annual Review. This report contains a description of the process and the results of the *2017 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

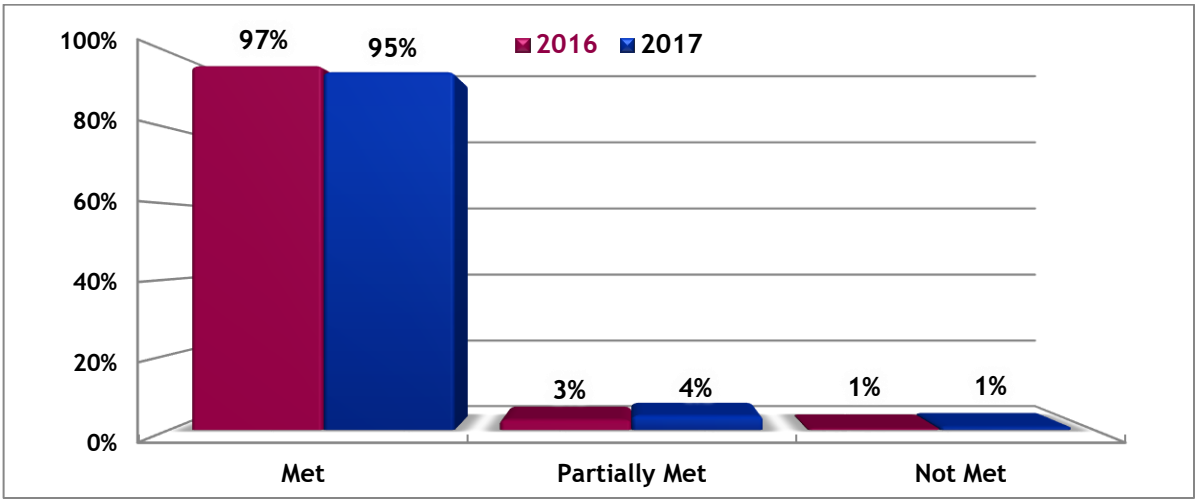
- Determine if ATC was in compliance with service delivery as mandated in the MCO contract with SCDHHS.
- Evaluate the status of deficiencies identified during the 2016 Annual Review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Assure that contracted health care services are being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review included a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects (PIPSs), validation of performance improvement measures, and validation of satisfaction surveys.

Overall Findings

The 2017 annual EQR review shows ATC achieved a "Met" score in 95% of the standards reviewed. As the following chart indicates, 4% of the standards were scored as "Partially Met," and 1% of the standards scored as "Not Met." The following chart provides a comparison of ATC's current review results to the 2016 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items, and recommendations can be found further in the narrative of this report.

Administration:

ATC has well-organized policies and procedures that are consistently reviewed and available to all employees via a shared Intranet. A review of the organizational chart and onsite discussion shows an experienced leadership team with appropriate staffing in place to meet contract requirements and the healthcare needs of ATC's members. The Information Systems Capabilities Assessment (ISCA) showed a well-documented system, proper turn-around times on claims, HIPAA-compliant electronic transactions, and the ability to provide other state-required data. ATC is capable of satisfying the IT security and access requirements of the contract and they have a detailed disaster recovery and business continuity plan.

Provider Services:

The Credentialing Committee is chaired by Medical Director Dr. Robert Thompson. Additional voting members include Medical Director Dr. Cheryl Walker-McGill and three network providers with the specialties of pediatrics and surgery. Onsite discussion confirmed a Behavioral Health representative was recently added to the committee. With the migration of behavioral health responsibilities from Cenpatico back to the health plan, ATC indicated the credentialing responsibilities will remain with Cenpatico until later in 2018.

Issues relating to the Credentialing Program included the following items. The Termination for Cause List is not mentioned in any of the credentialing policies or documents as a query responsibility, and was not evident in the credentialing/ recredentialing files. The ongoing monitoring policy did not address querying the Termination for Cause List or the Social Security Death Master File (SSDMF). The Cenpatico files had issues with their Credentialing Checklist and files not showing evidence of query of the SSDMF or the SC Excluded Providers List, and with hospital admitting arrangements not being addressed.

CCME conducted a Telephonic Provider Access Study focusing on primary care providers. Results showed calls were successfully answered 51% of the time (143 out of 278) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 43%, this year had a statistically significant increase in successful calls.

Member Services:

ATC's Member Services Call Center meets contractual requirements for hours of availability and options to leave a voice message or speak with the Nurse Advice Line. The call center consistently meets or exceeds call metrics as defined in the *SCDHHS Contract*.

The Member Handbook provides most information members will need to understand the health plan and its benefits. However, CCME identified a few issues regarding specific benefits, co-payments, and the grievance process that need correction.

A survey vendor conducts annual Member Satisfaction Surveys and an internal workgroup analyzes survey results and develops interventions to improve member satisfaction. ATC offers results of the CAHPS survey to providers and reports outcomes to the QIC. CCME offered suggestions to increase the survey response rates.

Several issues were noted in documentation of grievance processes and requirements in the grievance policy, Member Handbook, Provider Manual, Initial Resolution Letter, and ATC's website. Minor issues were noted in grievance files.

Quality Improvement:

ATC's *2017 Medicaid Quality Assessment and Performance Improvement Program Description* outlines how the program measures and improves the care and services received by members and providers. ATC's Board of Directors has ultimate authority and responsibility for the QI Program. The Board delegates these responsibilities to the Quality Improvement Committee (QIC). This committee is comprised of senior

management and network practitioners. Dr. Cheryl Walker-McGill, Medical Director, serves as the chairman.

ATC uses Inovalon, a certified software organization for calculation of HEDIS rates. The comparison from the previous to the current year revealed a strong increase in childhood immunization rates, lead screening in children, and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. The measure with the most significant decrease was the Statin Adherence at 80% measures.

CCME validated two projects using the CMS Protocol for Validation of Performance Improvement Projects. They included Member Satisfaction and Retinal or Dilated Eye Exam. Both projects scored within the "High Confidence" range and met the validation requirements.

Utilization Management:

The Utilization Management (UM) Program Description and departmental policies provide detailed information for staff on the UM program's functions, requirements, and processes. Members and providers can obtain information on UM processes and requirements via the Member Handbook, Provider Manual, and ATC's website. A few issues were noted in documentation of UM processes and/or requirements in UM policies, the Provider Manual, and the ATC website regarding pharmacy authorization processes and member appeals processes and requirements.

Overall, UM approval and denial files provided evidence that appropriate processes are followed. Two denial files did not clearly reflect that additional clinical information was requested when necessary. Appeal files reflected appropriate processes are followed. However, one appeal resolution letter incorrectly identified the reviewing physician's specialty.

Case Management and Care Transitions processes are well-documented in the Care Management Program Description and in policies. CCME recommended that information in the UM Program Description regarding Preventive and Rehabilitative Services for Primary Care Enhancement and Targeted Case Management should be clarified to reflect these are separate and distinct processes.

Delegation:

ATC delegates various functions such as behavioral health, pharmacy benefit management, vision, nurse hotline, disease management, radiology, and credentialing/recredentialing. Onsite discussion confirmed delegated vendor, Envolve PeopleCare, is currently transitioning multiple behavioral health delegated services (Provider Relations, Network Care Management, and Call Center) back to the health

plans. Transitions are expected to be completed by April 1, 2018. The credentialing process will be transitioned later in 2018.

The Oversight of Delegation Credentialing Policy had outdated attachments/exhibits. Evidence of annual oversight review was received for all delegated entities and a few issues were identified. One entity had a file review completed using a CA Credentialing File Audit Tool. Another entity was identified as not collecting ownership disclosure forms or querying the SSDMF and it did not appear ATC took action to ensure the deficiencies were addressed.

State Mandated Services:

ATC educates providers about the EPSDT program, provider responsibilities, and documentation requirements in various ways. ATC also provides PCPs with monthly reports of newly enrolled EPSDT eligible members and lists of members who are out of compliance with EPSDT recommendations, including immunizations. EPSDT related care gap alerts are displayed on the Provider Portal. Provider compliance with provision of recommended EPSDT services and immunizations is evaluated through the annual medical record review process. ATC provides all core benefits required by the *SCDHHS Contract*.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2016 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2016	33	0	0	0	0	33
2017	39	0	0	0	0	39
Provider Services						
2016	71	3	1	0	0	75
2017	71	4	3	0	0	78
Member Services						
2016	35	2	0	0	0	37
2017	30	2	0	0	0	32
Quality Improvement						
2016	15	0	0	0	0	15

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
2017	15	0	0	0	0	15
Utilization						
2016	37	1	0	0	0	38
2017	44	1	0	0	0	45
Delegation						
2016	2	0	0	0	0	2
2017	1	1	0	0	0	2
State Mandated Services						
2016	4	0	0	0	0	4
2017	4	0	0	0	0	4

METHODOLOGY

The process used by CCME for the EQR was based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally-mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On December 4, 2017, CCME sent notification to ATC that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow ATC to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from ATC on December 18, 2017 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeals files.

The second segment was an onsite review conducted on March 1, 2018 and March 2, 2018 at the ATC office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or requiring clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following sections and are based on the regulations set forth in title *42 of the Code of Federal Regulations (CFR), part 438*, and the contract requirements between ATC and SCDHHS. Strengths, weaknesses and recommendations are identified where applicable. CCME identified areas of review as meeting a standard, "Met," acceptable but needing improvement, "Partially Met," failing a standard, "Not Met," or "Not Applicable," or "Not Evaluated," on the tabular spreadsheet (Attachment 4).

A. Administration

The Administration review focused on Absolute Total Care's (ATC) policies, procedures, staffing, information systems, compliance, and confidentiality. ATC policies and procedures are well-organized and are consistently reviewed and updated, as appropriate. Corporate policies addressing multiple product types contain footnotes or

attachments addressing SC specific information. Other policies are specific to SC Medicaid. Policies are reviewed annually. All employees have access to the policies via a shared Intranet.

Paul Accardi is the Plan President and CEO responsible for ATC's day-to-day business activities. He is accountable to the Board of Directors and ATC's parent organization, Centene Corporation, located in St. Louis, Missouri. Dr. Robert Thompson is a full-time Medical Director, currently licensed in South Carolina as a doctor of osteopathic medicine (DO) specializing in family practice. Dr. Thompson chairs the Credentialing Committee, and serves as a member of the Pharmacy & Therapeutics Committee, HEDIS Steering Committee, QI Committee, and ATC Vendor Oversight Committee. Dr. Cheryl Walker-McGill and recently hired, Dr. William Logan, also serve as full-time Medical Directors. The Medical Directors oversee the clinical functions of the organization.

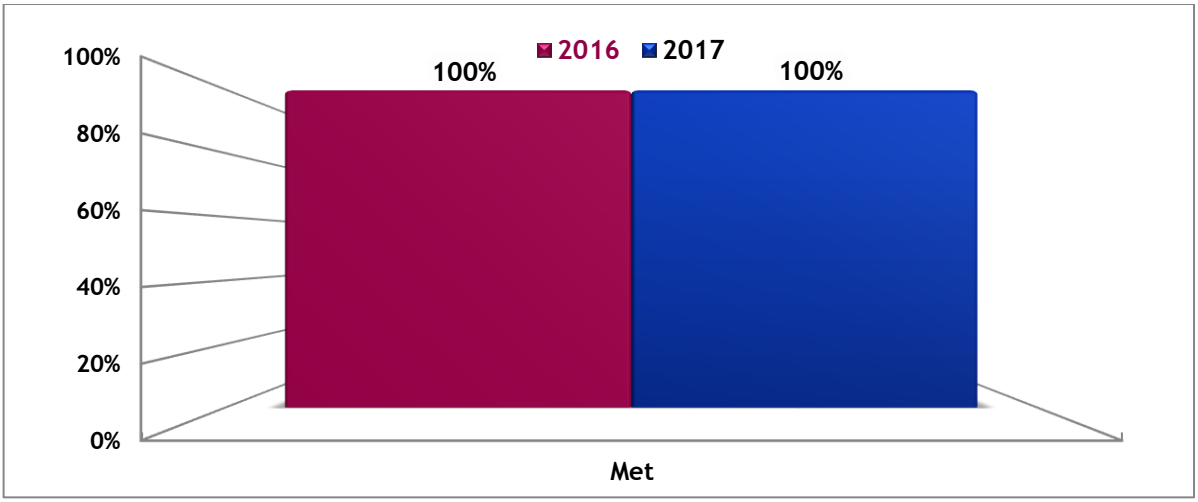
The Information Systems Capabilities Assessment (ISCA) showed ATC has a well-documented system with appropriate turn-around times on claims. Results showed 99.9% of clean claims were processed within 30 days with 100% of clean claims being processed within 90 days. ATC's documentation states their systems accept, handle, and generate HIPAA-compliant electronic transactions. ATC utilizes Amisys Advanced as its primary claims system. They are able to collect enrollment data and perform demographic monitoring. The task of auditing the MCO's database team and verifying the records reported is performed by KPMG, LLC.

ATC's policies and procedures for data security are comprehensive and indicate the MCO is capable of satisfying the access requirements of the contract. Additionally, ATC provided a recent audit report from KGMP, LLC which included a thorough examination of ATC's data security capabilities and IT security and access management capabilities. The MCO's documentation contains a detailed disaster recovery (DR) and business continuity plan. A DR test of ATC's telecommunications system was performed in June 2017, followed by a DR test of their data center in September 2017. ATC states all systems passed the tests.

Multiple policies, the Compliance Plan, and the Fraud, Waste, and Abuse Plan address federal and *SCDHHS Contract* requirements for detecting and preventing fraud, waste, and abuse.

Figure 2, Administration Findings, indicates ATC received a "Met" score for all the standards in the Administration section.

Figure 2: Administration Findings



Strengths

- The Information Systems Capability Assessment showed thorough documentation on system security practices and complete documentation on workflow and processes.
- ATC meets requirements and surpasses the MCO contract requirements regarding claims payment. Results showed 99.9% of clean claims were processed within 30 days with 100% of clean claims being processed within 90 days.

Weaknesses

- The organizational chart received in the desk materials did not include all Medical Directors employed by ATC.

Recommendations

- Update the organizational chart to reflect all Medical Directors and their reporting structure.

B. Provider Services

CCME conducted a review of all Provider Services policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing/recredentialing files, and practice guidelines. The Credentialing Committee is chaired by Medical Director Dr. Robert Thompson. Additional voting members include Medical Director Dr. Cheryl Walker-McGill and three network providers with specialties of pediatrics and surgery. Onsite discussion confirmed a behavioral health representative was recently added to the committee. With the migration of behavioral health

responsibilities from Cenpatico back to the health plan, ATC indicated the credentialing responsibilities will remain with Cenpatico until later in 2018.

Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, establishes standards for conducting the functions of practitioner selection and retention. Additional policies address various credentialing/recredentialing activities. The Termination for Cause List is not mentioned in any of the credentialing policies or documents as a query responsibility. The credentialing and recredentialing file review showed no evidence of the query as well. Other credentialing/recredentialing file review issues related to the Cenpatico behavioral health credentialing/recredentialing files. There was no evidence of search of the Social Security Death Master File (SSDMF) or the SC Excluded Provider List, and hospital admitting arrangements were not addressed in the behavioral health files. The Cenpatico files contained a query for OIG Compliance NOW, LLC which is performed by Aperture. ATC indicated the SSDMF and the SC Excluded Providers List are search items. However, there was no evidence they are a part of the query for OIG Compliance NOW. In addition, the Cenpatico Credentialing Checklist did not list the SSDMF or the SC Excluded Providers List as verified documents.

CCME received and reviewed GeoAccess reports showing ATC used correct standards for measuring network access. ATC has a solid network with access exceeding contract requirements.

Provider Access and Availability Study

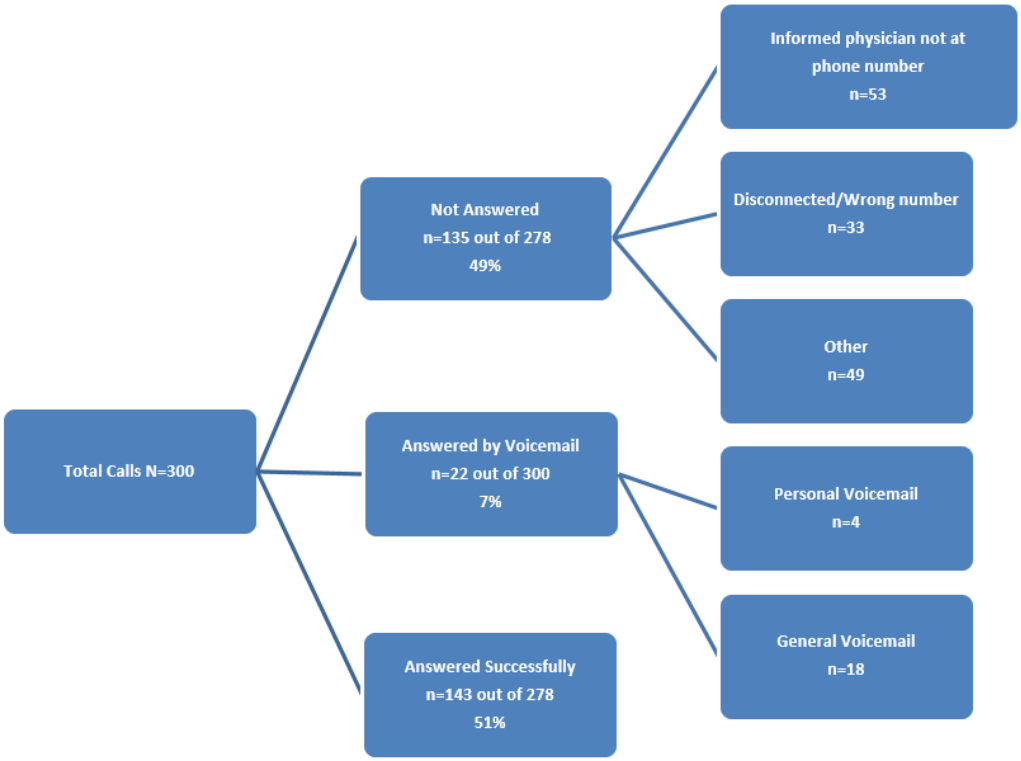
As part of the annual EQR process for ATC, a telephonic provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,988 unique PCPs was found. A sample of 300 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the contracted providers.

Table 2: Telephone Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact P-value
2016 Review	300	43%	.038
2017 Review	300	51%	

The results of the Telephonic Provider Access Study, conducted by CCME, demonstrated calls were successfully answered 51% (143 out of 278) of the time when omitting calls answered by personal or general voicemail messaging services (see Figure 3 below).

Figure 3: Telephonic Provider Access Study Results



When compared to last year's results of 43%, this year had a statistically significant increase in successful calls (p=.04).

For calls not answered successfully (n=135 calls), 53 (39%) were unsuccessful because the provider was not at the office or phone number listed. Of the 143 successful calls, 122 (85%) of the providers indicated they accept ATC, and one (<1%) indicated this occurred only under certain conditions. Of the 122 accepting ATC, 85 (70%) responded they are accepting new Medicaid patients.

Regarding a screening process for new patients, 53 (52%) of the 102 providers responding to the item indicated an application or prescreen was necessary. Of those 53, 10 (19%) indicated an application must be filled out, whereas 11 (21%) required a review of

medical records before accepting a new patient and 10 (10%) required both. When the office was asked about the next available routine appointment, 64 (64%) of the 100 responses met contact requirements.

Figure 4, Provider Services Findings, shows 91% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings

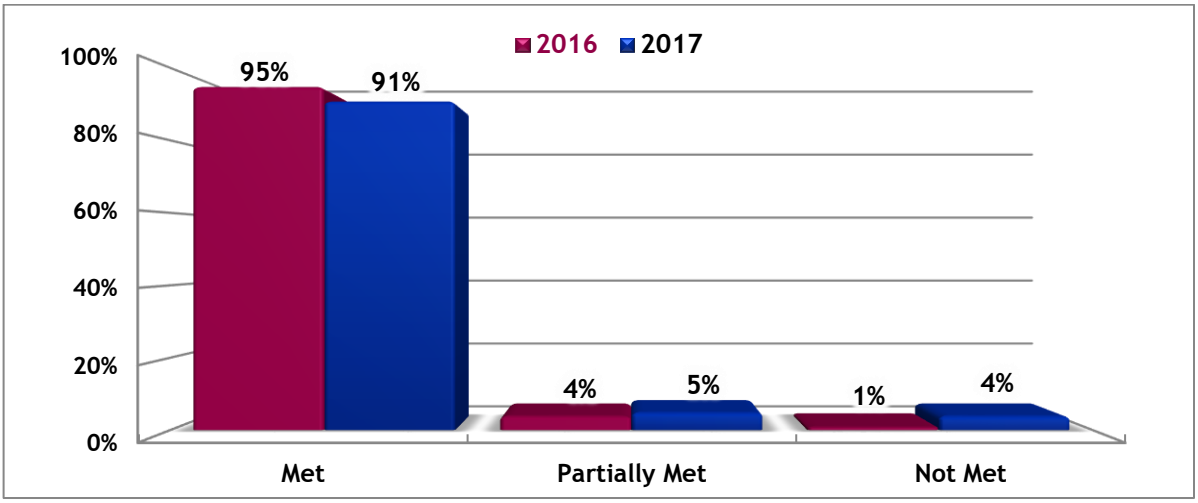


Table 3: Provider Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met
	Credentialing: In good standing at the hospital designated by the provider as the primary admitting facility	Met	Partially Met
	Recredentialing: In good standing at the hospital designated by the provider as the primary admitting facility	Met	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Not Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Partially Met
Adequacy of the Provider Network	Members have a primary care physician located within a 30-mile radius of their residence.	Partially Met	Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Telephonic Provider Access Study success rates increased with the new calculation formula for success rate.
- In 2017, ATC conducted an evaluation of accuracy of the online Provider Directory by conducting a phone survey of providers. This identified opportunities for improvement in the areas of "office phone numbers" and "accepting new patients."

Weaknesses

- Policy CC.CRED.01, Practitioner Credentialing & Recredentialing had the following issues:
  - Footnote 37 references Policy SC.CRED.13 which is no longer an active policy.
  - Footnote 42 and Attachment J reference the SC Excluded Provider Listing. However, they do not reference the Termination for Cause List as required by the *SCDHHS Policy and Procedure (P&P) Guide, Sections 11.1 and 11.2.*
- The 2017 QI Program Description states the Credentialing Committee quorum is met with a minimum of three voting members in attendance. It was confirmed onsite the quorum is met with 2/3 of the voting members in attendance as stated in Policy CC.CRED.03.
- The credentialing/recredentialing file review reflected the followed issues:

  - Proof of query of the Termination for Cause List was not present in any files reviewed.
  - Cenpatico files contained a search for OIG Compliance NOW indicating searches completed for South Carolina State Exclusions. However, it could not be determined which lists were queried. The Cenpatico Credentialing Checklist did not specify the SC Excluded Providers List or the Terminated for Cause List as document review items even though other queries completed by Compliance NOW were listed, such as OIG and SAM.
  - The Cenpatico licensed professional counselors (LPC) behavioral health files did not contain proof of query of the SSDMF. During onsite discussion, ATC indicated the search is included during all OIG Compliance NOW, LLC searches performed by Aperture. However, the OIGCN Database Sources document indicated it required additional fees and processing, and the SSDMF was not listed as a document verified on the Cenpatico Credentialing Checklist.
  - Cenpatico LPC files did not address hospital admitting arrangements. Onsite discussion confirmed Cenpatico does not pursue hospital admitting arrangements for behavioral health providers; however, admitting arrangements should be addressed for all providers.

- Policy SC.CRED.05, Organizational Assessment and Reassessment, Attachment M, does not address the requirement for the Termination for Cause List and the file review did not reflect proof of the queries.
- Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, Attachment J, does not address the monitoring of the Termination for Cause List or the SSDMF that is required in the *SCDHHS Contract, Section 11.2.11* and the *SCDHHS P&P Guide, Sections 11.1 and 11.2*.
- Policies SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability, and SC.CONT.02, Network Adequacy, do not include the drive time standards for measuring the availability of network providers.
- ATC has adopted several behavioral health practice guidelines such as ADHD treatment guidelines, bipolar disorder, and major depressive disorder. It was noted there does not appear to be practice guidelines regarding substance abuse.

Quality Improvement Plans

- Update Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to correct Footnote 37, update Footnote 42, and update Attachment J to reflect the Termination for Cause List as a query item.
- Credentialing and recredentialing files should contain evidence of query of the Termination for Cause List.

- The Cenpatico Credentialing Checklist should be updated to document the required SC Medicaid queries: SC Excluded Providers List and the Termination for Cause List.
- Ensure proof of query of the SSDMF is included in each Cenpatico credentialing/ recredentialing file. The Cenpatico Credentialing Checklist should be updated to document the required SSDMF query.
- Update Policy SC.CRED.05, Organizational Assessment and Reassessment, Attachment M, to include the Termination for Cause List as a required query.
- Update Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, and Attachment J to address the process of monitoring the Termination for Cause List and the SSDMF on a monthly basis.

Recommendations

- Update the 2017 QI Program Description to reflect the quorum for the Credentialing Committee is met with 2/3 of voting members in attendance.
- Regarding the Cenpatico file review, ensure hospital admitting arrangements are addressed for all providers during the credentialing/recredentialing process.
- Update Policies SC.QI.04 and SC.CONT.02 to reflect the drive time standards for measuring PCP network availability.
- Update Policies SC.QI.04 and SC.CONT.02 to reflect the drive time standards for measuring network availability for specialists and hospitals.
- Consider adopting practice guidelines to address substance abuse.

C. Member Services

ATC's Member Services Call Center is in SC and is available via a toll-free telephone number from 8:00 am to 6:00 pm Monday through Friday. Outside of normal business hours, an automated line provides information on office hours, instructions for verifying eligibility, and instructions on what to do in case of an emergency. Callers may leave a voicemail for a response within one business day or they may speak immediately with the Nurse Advice Line. In addition to the Member Services Call Center, members may also speak with the Nurse Advice Line 24 hours a day, seven days a week.

To furnish members with sufficient information to understand the health plan and their benefits, members are sent a new member packet containing a Member Handbook, ID Cards, and other new member materials within 14 days of receipt of enrollment information from SCDHHS. The Member Handbook is available on the ATC website, along with a change control record to document any updates or changes. ATC recently revised the Member Handbook and is awaiting final approval from SCDHHS. When approval is

received, the new handbook will be posted to the ATC website. Issues identified in the Member Handbook include incorrect information regarding coverage of elective abortions, co-payment discrepancies, and lack of information regarding expedited grievances.

A certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, Morpace, conducts ATC's annual Member Satisfaction Surveys. Although the actual sample sizes for the survey were adequate and met the NCQA minimum sample size and number of valid surveys, the response rates were below NCQA's target of 40%. CCME offered recommendations to increase the response rates for future surveys. ATC has established a work group to analyze and develop interventions to improve member satisfaction. Results of the CAHPS survey are offered to providers and outcomes are presented to the QIC.

A review of grievance processes and requirements revealed several issues. ATC's website documents an incorrect timeframe for filing grievances. Processes for clinically urgent/expedited grievances are incomplete in the Member Grievances policy. The Member Handbook, Provider Manual, and ATC website contain no information regarding the availability of the clinically urgent/expedited grievance process. ATC has established a process for second review of grievances for which the member is dissatisfied with the initial grievance outcome. However, the initial Grievance Resolution Letter informs of the option of a Second Review grievance but does not define the timeframe to request one.

Issues identified in the grievance files reviewed included incomplete documentation of investigations conducted by staff in other departments, incorrect or vague identification of grievance type in grievance resolution letters, and use of abbreviations members may not understand in grievance resolution letters.

As noted in the following chart, 94% of the standards for Member Services received a score of "Met." Reasons for the scores of "Partially Met" are described in the Weaknesses section that follows.

Figure 5: Member Services Findings

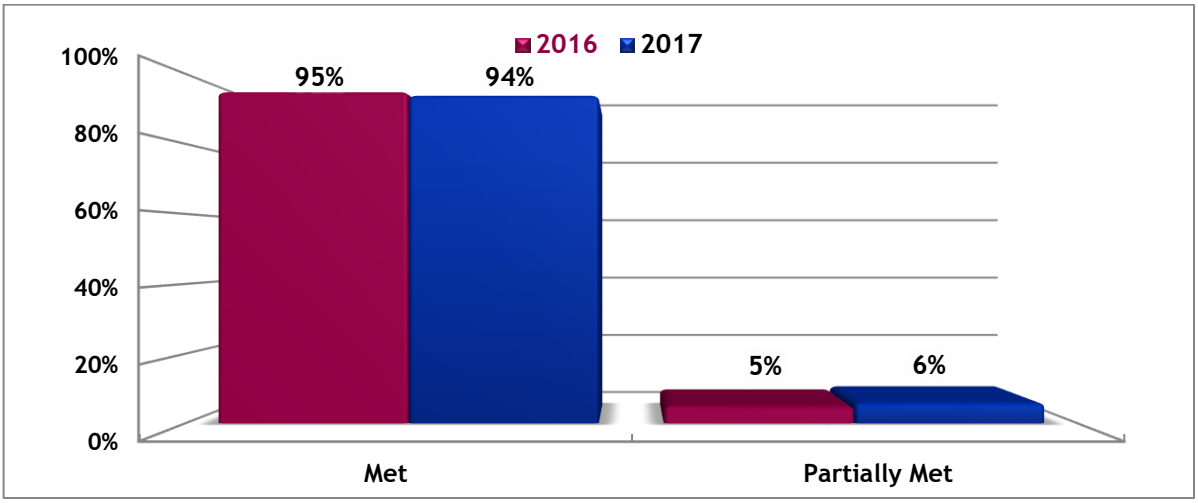


Table 4: Member Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information	Met	Partially Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to the procedure for filing and handling a grievance	Met	Partially Met
	Timeliness guidelines for resolution of the grievance as specified in the contract	Met	Partially Met
	Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Partially Met	Met
	The MCO applies the grievance policy and procedure as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- The detailed search function of the online Find a Provider Tool allows members to search for providers by name, specialty, gender, those accepting new patients, after hours/weekend availability, accessibility to those with disabilities, NPI number, group/hospital affiliation, and languages spoken by the practitioner and/or in the office.
- ATC contracted with ExamOne to perform free health screenings in members' homes to encourage preventive care. Results are provided to the member and his/her provider.
- Data presented to the QIC in December 2017 confirms call center metrics are consistently met or exceeded.

Weaknesses

- Page 18 of the Member Handbook states elective abortions are not covered.
- Discrepancies in co-payments are noted as follows:
  - The Member Handbook, Provider Manual, and ATC website indicate the copayment for ambulatory surgery center is $3.40, but the *SCDHHS Policy and Procedure Guide, Section 7.5* lists the co-payment as $3.30.
  - The ATC website lists the co-payment for outpatient hospital non-emergent services as $3.40. *The Member Handbook and Provider Manual* do not specify a co-payment for this category of services.
- The response rates for the Member Satisfaction Survey were below the NCQA target of 40%.
- The ATC website incorrectly states grievances can be filed within 30 calendar days of the occurrence.
- Issues related to clinically urgent/expedited grievances include:
  - Policy SC.UM.11, Member Grievances, includes a resolution timeframe of 72 hours for clinically urgent grievances but does not define a process for receiving and processing expedited/clinically urgent grievances.
  - The Member Handbook, Provider Manual, and ATC website contain no information regarding the availability of the expedited/clinically urgent grievance process.
  - The Member Handbook, Provider Manual, and ATC website do not define the timeframe for clinically urgent grievance resolution.
- The initial Grievance Resolution Letter informs of the availability of the Second Review grievance but does not define the timeframe to request a Second Review grievance.

- Issues noted in the grievance files include:
  - Incomplete documentation of investigations conducted by staff in other departments
  - Incorrect identification of grievance type and use of "other" to define the grievance type in grievance resolution letters
  - Use of abbreviations members may not understand in grievance resolution letters

Quality Improvement Plans

- Correct the information regarding coverage of elective abortions in the Member Handbook, page 18. Refer to the *SCDHHS Contract, Section 4.2.1*, Policy SC.UM.33, Abortions, and the Provider Manual.
- Correct the co-payment discrepancies in the Member Handbook, Provider Manual, and on the website.
- Ensure the ATC website is updated to indicate there is no limit on the time allowed to file a grievance. Refer to *Federal Regulation § 438.402 (c) (B) (4) (ii) (2)* and the *SCDHHS Contract, Section 9.1.1.2.1.*
- Update Policy SC.UM.11, Member Grievances, to specify all applicable processes for receiving and processing clinically urgent (expedited) grievances.
- Update the Member Handbook, Provider Manual, and ATC website to include information about the availability of expedited grievance processing.
- Include the timeframe for clinically urgent grievance resolution in the Member Handbook, Provider Manual, and on the ATC website.
- Update the initial Grievance Resolution Letter to specify the timeframe to request a Second Review grievance.

Recommendations

- Continue working with Morpace to increase Member Satisfaction Survey response rates. Possible interventions for increasing response rates include adding reminders to call center scripts, maximizing the oversampling, and allowing a longer timeline for additional reminders to be sent and phone call surveys to be conducted. Decide upon and document an internal goal to increase response rates (such as a 3% increase each year).
- Ensure grievance investigations conducted by other departments are thoroughly documented in grievance files.
- Ensure grievance resolution letters correctly identify the type of grievance and do not contain abbreviations.

D. Quality Improvement

ATC's *2017 Medicaid Quality Assessment and Performance Improvement Program Description* approved on August 17, 2017, outlines how the program measures and improves the care and services received by members and providers. ATC's Board of Directors has ultimate authority and responsibility for the QI Program. The Board delegates these responsibilities to the Quality Improvement Committee (QIC). This committee is comprised of senior management and network practitioners. Dr. Cheryl Walker-McGill, Medical Director, serves as the Chairman.

Per QI Program Description, ATC encourages practitioners to participation in ATC's Program initiatives through the Quality Improvement, Credentialing, and Peer Review Committees. This requirement is also addressed in the provider agreements. At least annually, ATC provides information, including a description of the QI Program and a report on progress to meeting program goals, to members and providers. At a minimum, the communication includes information about processes and outcomes as they relate to member care and services and ATC's specific data results such as HEDIS, CAHPS, and results of Performance Improvement Projects.

At least annually, the QI Department supports a formal evaluation of the effectiveness of the program. ATC offered CCME the *2016 Quality Assessment and Performance Improvement Program Evaluation*. This evaluation provides an analysis of the Plan's performance and evaluates the overall effectiveness of the program.

Performance Measure Validation

CCME conducted a Validation Review of the HEDIS performance measures following CMS developed protocols. This process assesses the application of these measures by ATC to confirm reported information is valid. ATC uses Inovalon, a certified software organization for calculation of HEDIS rates. The comparison from the previous to the current year revealed a strong increase in childhood immunization rates and lead screening in children and increased Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. The measure with the most significant decrease was the Statin Adherence at 80%. All relevant HEDIS performance measures are detailed in *Table 5*: HEDIS *Performance Measure Data*.

Table 5: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	77.38%	87.35%	9.97%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	58.89%	68.75%	9.86%
Counseling for Nutrition	46.88%	56.01%	9.13%
Counseling for Physical Activity	37.50%	44.71%	7.21%
Childhood Immunization Status (cis)			
DTaP	70.36%	78.61%	8.25%
IPV	85.78%	91.35%	5.57%
MMR	84.34%	91.59%	7.25%
HiB	80.24%	86.06%	5.82%
Hepatitis B	85.78%	93.03%	7.25%
VZV	84.58%	92.55%	7.97%
Pneumococcal Conjugate	68.43%	81.97%	13.54%
Hepatitis A	75.66%	86.78%	11.12%
Rotavirus	66.99%	73.80%	6.81%
Influenza	32.29%	43.51%	11.22%
Combination #2	63.86%	76.68%	12.82%
Combination #3	60.24%	75.48%	15.24%
Combination #4	56.39%	72.60%	16.21%
Combination #5	49.16%	64.18%	15.02%
Combination #6	26.51%	38.70%	12.19%
Combination #7	47.47%	62.98%	15.51%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Combination #8	26.51%	38.22%	11.71%
Combination #9	23.37%	34.38%	11.01%
Combination #10	23.37%	33.89%	10.52%
Immunizations for Adolescents (ima)			
Meningococcal	66.59%	69.23%	2.64%
Tdap/Td	87.02%	83.89%	-3.13%
Combination #1	66.11%	67.79%	1.68%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	20.67%	24.28%	3.61%
Lead Screening in Children (lsc)	55.53%	68.51%	12.98%
Breast Cancer Screening (bcs)	59.37%	60.50%	1.13%
Cervical Cancer Screening (ccs)	64.55%	61.92%	-2.63%
Chlamydia Screening in Women (chl)			
16-20 Years	51.02%	55.14%	4.12%
21-24 Years	63.71%	65.08%	1.37%
Total	55.16%	58.53%	3.37%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	70.27%	74.30%	4.03%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	21.59%	27.33%	5.74%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	51.51%	56.65%	5.14%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Bronchodilator	81.33%	83.43%	2.10%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	42.33%	47.96%	5.63%
5-11 Years - Medication Compliance 75%	18.99%	20.43%	1.44%
12-18 Years - Medication Compliance 50%	41.26%	43.52%	2.26%
12-18 Years - Medication Compliance 75%	15.76%	20.47%	4.71%
19-50 Years - Medication Compliance 50%	47.89%	45.60%	-2.29%
19-50 Years - Medication Compliance 75%	26.76%	25.27%	-1.49%
51-64 Years - Medication Compliance 50%	69.44%	64.10%	-5.34%
51-64 Years - Medication Compliance 75%	22.22%	33.33%	11.11%
Total - Medication Compliance 50%	43.60%	46.67%	3.07%
Total - Medication Compliance 75%	19.07%	21.62%	2.55%
Asthma Medication Ratio (amr)			
5-11 Years	67.93%	74.75%	6.82%
12-18 Years	53.67%	60.33%	6.66%
19-50 Years	42.70%	49.56%	6.86%
51-64 Years	60.42%	62.50%	2.08%
Total	59.30%	65.18%	5.88%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	43.58%	35.88%	-7.70%
Persistence of Beta-Blocker Treatment After a Heart	60.00%	65.38%	5.38%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Attack (pbh)			
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	70.00%	69.36%	-0.64%
Statin Adherence 80% - 21-75 years (Male)	60.39%	34.36%	-26.03%
Received Statin Therapy - 40-75 years (Female)	64.10%	66.31%	2.21%
Statin Adherence 80% - 40-75 years (Female)	61.00%	29.84%	-31.16%
Received Statin Therapy – Total	67.55%	68.01%	0.46%
Statin Adherence 80% - Total	60.63%	32.40%	-28.23%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	85.65%	88.37%	2.72%
HbA1c Poor Control (>9.0%)	52.55%	47.40%	-5.15%
HbA1c Control (<8.0%)	39.81%	41.49%	1.68%
HbA1c Control (<7.0%)	NR	31.13%	
Eye Exam (Retinal) Performed	51.39%	54.34%	2.95%
Medical Attention for Nephropathy	90.97%	93.06%	2.09%
Blood Pressure Control (<140/90 mm Hg)	43.06%	46.88%	3.82%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	54.89%	55.76%	0.87%
Statin Adherence 80%	40.06%	33.92%	-6.14%
Effectiveness of Care: Musculoskeletal Conditions			

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	59.26%	65.55%	-6.14%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	36.20%	36.81%	0.61%
Effective Continuation Phase Treatment	22.63%	22.17%	-0.46%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	50.16%	53.02%	2.86%
Continuation and Maintenance (C&M) Phase	64.32%	63.60%	-0.72%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	62.36%	60.11%	-2.25%
7-Day Follow-Up	40.68%	40.43%	-0.25%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	--	55.64%	NA
7-Day Follow-Up	--	39.03%	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.00%	76.80%	1.80%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	63.64%	69.06%	5.42%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	61.54%	85.00%	23.46%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	55.15%	55.84%	0.69%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
1-5 Years	NA	12.50%	NA
6-11 Years	17.59%	16.10%	-1.49%
12-17 Years	22.67%	29.69%	7.02%
Total	20.49%	24.21%	3.72%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	87.98%	89.59%	1.61%
Digoxin	48.48%	46.67%	-1.81%
Diuretics	88.59%	88.45%	-0.14%
Total	87.89%	88.74%	0.85%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	4.29%	2.93%	-1.36%
Appropriate Treatment for Children With URI (uri)	84.79%	86.85%	2.06%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	21.53%	31.25%	9.72%
Use of Imaging Studies for Low Back Pain (lbp)	70.51%	66.48%	-4.03%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NR	NA
6-11 Years	NR	NR	NA
12-17 Years	NR	NR	NA
Total	NR	NR	NA

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	80.24%	77.75%	-2.49%
45-64 Years	87.29%	86.38%	-0.91%
65+ Years	50.00%	100.00%	50.00%
Total	82.45%	80.24%	-2.21%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.21%	95.52%	-0.69%
25 Months - 6 Years	86.28%	85.32%	-0.96%
7-11 Years	87.91%	88.58%	0.67%
12-19 Years	86.56%	87.01%	0.45%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	33.96%	32.41%	-1.55%
Engagement of AOD Treatment: 13-17 Years	17.61%	15.17%	-2.44%
Initiation of AOD Treatment: 18+ Years	36.36%	39.84%	3.48%
Engagement of AOD Treatment: 18+ Years	6.58%	8.83%	2.25%
Initiation of AOD Treatment: Total	36.18%	39.33%	3.15%
Engagement of AOD Treatment: Total	7.43%	9.26%	1.83%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.28%	90.09%	-0.19%
Postpartum Care	71.56%	67.69%	-3.87%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Call Answer Timeliness (cat)	90.41%	NR	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NR	66.67%	NA
6-11 Years	70.18%	60.34%	-9.84%
12-17 Years	55.13%	56.58%	1.45%
Total	61.03%	58.57%	-2.46%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	2.37%	2.83%	0.46%
21-40 Percent	2.37%	2.36%	-0.01%
41-60 Percent	5.21%	6.37%	1.16%
61-80 Percent	12.80%	12.74%	-0.06%
81+ Percent	77.25%	75.71%	-1.54%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.72%	1.92%	1.20%
1 Visit	1.93%	1.44%	-0.49%
2 Visits	3.38%	2.40%	-0.98%
3 Visits	5.31%	6.49%	1.18%
4 Visits	8.21%	10.34%	2.13%
5 Visits	20.53%	17.31%	-3.22%
6+ Visits	59.90%	60.10%	0.20%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCT
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	59.38%	59.33%	-0.05%
Adolescent Well-Care Visits (awc)	46.88%	52.88%	6.00%

NB: Not a benefit; NR: Not reported; NA: Data not available

Performance Improvement Project Validation

CCME validated PIPs in accordance with CMS protocol, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. Both projects were submitted last year and validated again this year. Table 6, *Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

Table 6: Performance Improvement Project Validation Scores

PROJECT	2016 VALIDATION SCORE	2017 VALIDATION SCORE
Member Satisfaction	125/125=100% High Confidence in Reported Results	120/126=95% High Confidence in Reported Results
Retinal or Dilated Eye Exam (Clinical)	131/131=100% High Confidence in Reported Results	131/131=100% High Confidence in Reported Results

Both projects scored in the "High Confidence" range. This year, there are two recommendations for the Member Satisfaction PIP noted in Table 7, Performance Improvement Project Errors and Recommendations.

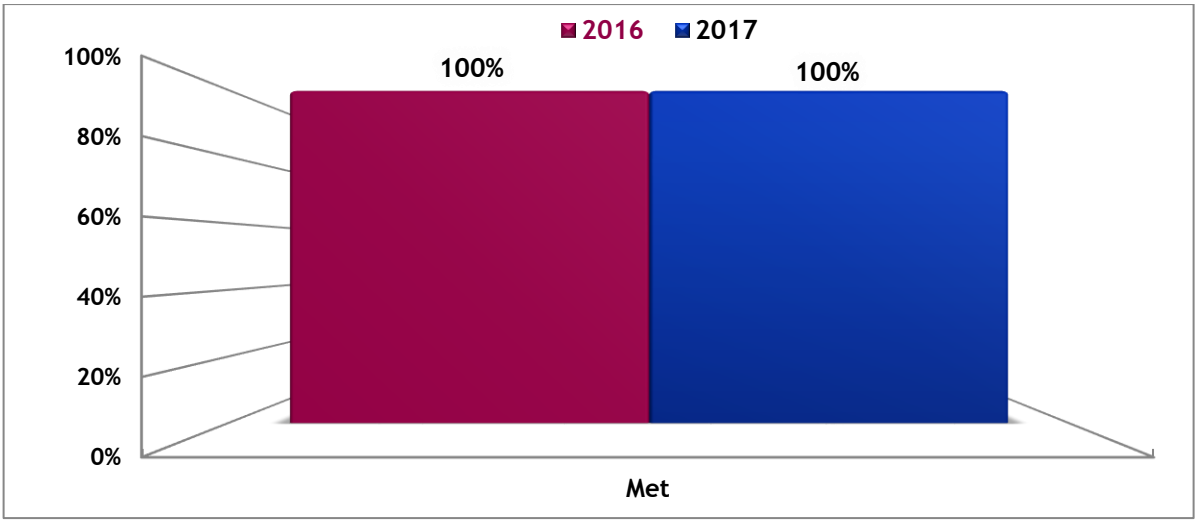
Table 7: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Member Satisfaction	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	PIP results were presented clearly. However, the benchmark rate for Remeasurement 2 in the results section does not match the benchmark rate in the definition of the indicator section.	Update the results section, p.24 to reflect the benchmark of 78.8% for Remeasurement 2, which was the benchmark stated on page 3.
Member Satisfaction	Is there any statistical evidence that any observed performance improvement is true improvement?	The increase in rate was not statistically significant.	Continue interventions to further increase rate enough to achieve statistical significance.

Details of the validation of the performance measures and PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 6, Quality Improvement Findings, indicate that all of the standards received a "Met" score.

Figure 6: Quality Improvement Findings



Strengths

- PIPs were based on analysis of comprehensive aspects of member needs and services with rationale documented for each topic. Both PIPs received excellent validation scores.
- ATC's *2016 Quality Assessment and Performance Improvement Program Evaluation* was comprehensive and provided an analysis of the ATC's performance and evaluates the overall effectiveness of the program.

E. Utilization Management

Absolute Total Care's Utilization Management (UM) Program Description is specific to the SC Medicaid Managed Care line of business and provides an overview of the structure and operations of the UM Department, as well as the program's purpose, goals, scope, and lines of authority and oversight.

Departmental policies provide detailed information on the UM program's functions, requirements, and processes. However, CCME noted issues in policy documentation regarding timeliness requirements for pharmacy authorization determinations and notifications, as well as and documentation regarding members' ability to obtain specialty pharmaceuticals from a local pharmacy when immediate access is necessary.

Members and providers can obtain information on UM processes and requirements in various ways, including the Member Handbook, Provider Manual, and ATC's website. During the onsite visit, a revised version of the Member Handbook, pending approval from SCDHHS, was presented to CCME and showed issues identified during the desk review had already been corrected.

UM approval and denial files, overall, reflected timely determinations and use of appropriate medical necessity criteria. In most of the files, it was evident that additional clinical information was requested when necessary. However, this was not clear in two denial files and CCME encouraged ATC to ensure staff request additional information when appropriate.

ATC's policies guide staff in the handling and processing of appeals. Information regarding appeals processes and requirements are also found in the Member Handbook, Provider Manual, and on the ATC website. Issues noted in documentation of appeals information included:

- The Provider Manual and ATC website contain outdated appeals terms and the ATC website contains an incomplete definition of an adverse benefit determination.

- The ATC website provides an incorrect version of the form members use to appoint a representative.
- The timeframe to file an appeal is incorrect on the ATC website and in the UM Program Description.

Appeal files reflected required acknowledgements, appropriate MD reviewers, and timely resolutions and notifications. One appeal resolution letter incorrectly identified the reviewing physician's specialty. ATC staff reported this issue was already identified and additional training was provided to the appropriate employee.

Case Management (CM) and Care Transitions processes are well-documented in the Care Management Program Description and in policies. However, information in the UM Program Description regarding Preventive and Rehabilitative Services for Primary Care Enhancement (PSPCE/RSPCE) and Targeted Case Management was combined, and the terms used interchangeably. This could result in confusion for staff members. CCME encouraged ATC to clarify the information to show two separate and distinct processes.

As illustrated in Figure 7, 98% of the standards in the UM section received scores of "Met." All standards scored as "Partially Met" are discussed in detail in the Weaknesses section of this report.

Figure 7: Utilization Management Findings

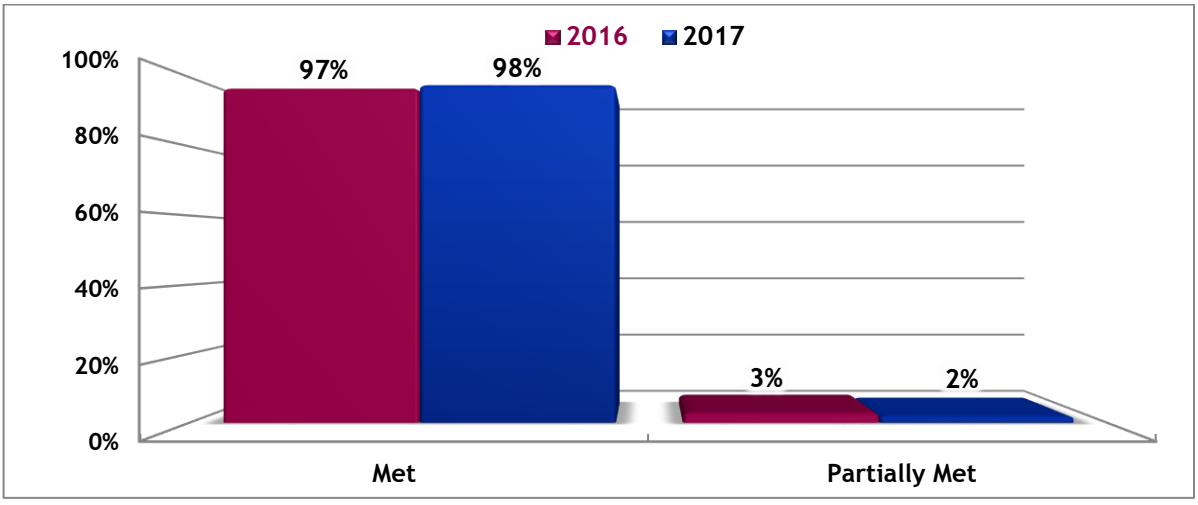


TABLE 8: Utilization Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: the definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Partially Met
	A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- ATC established a process for appeals nurses to review MD language for member understanding and obtain MD approval for alterations to ensure the language is in layman's terms.
- The ATC website contains links to many caregiver resource websites (such as the Alzheimer's Association, American Diabetes Association, etc.) and health and wellness information on topics pertinent to members (asthma, flu prevention, pregnancy, etc).

Weaknesses

- Issues noted in Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, include:
  - The policy does not define the timeframe or process followed when necessary/requested information is not received for pharmacy prior authorization requests.
  - The policy does not define the timeframe for faxing notification of a denial.
- Policy SC.PHAR.07, Specialty Pharmacy Program, defines requirements and processes for coverage of specialty medications, but does not address the requirement to allow members to obtain specialty pharmaceuticals from a local pharmacy when immediate access to the medication is necessary.
- Issues noted in denial files include:

  - It was unclear in two denial files reviewed whether necessary clinical information was requested.
  - One of the denial files showed the determination and notification were not compliant with established timeliness requirements.
- Issues related to the appeals process include:
  - Page 87 of the Provider Manual and the ATC website use the term "action" instead of "adverse benefit determination".
  - The ATC website does not include the full definition of an adverse benefit determination. Refer to the *SCDHHS Contract, Section 9.1 (b) (vii)*.
  - The ATC website "Member Handbooks and Forms" page provides the outdated Appointment of Authorized Representative form instead of the contractually required Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals form (DHHS Form 1282). Refer to the *SCDHHS Contract, Section 9.1.1.1.2*.
  - The ATC website documents an incorrect timeframe to file an appeal.
  - Page 22 of the UM Program Description documents an incorrect timeframe to file an appeal.
- One behavioral health appeal resolution letter incorrectly identified the reviewing physician's specialty as radiology instead of psychiatry.
- Page 15 of the UM Program Descriptions contains the header, "Preventive and Rehabilitative Services for Primary Care Enhancement (PSPCE/RSPCE) and Targeted Case Management." Information about these separate services were combined and the terms are used interchangeably. This could result in confusion for staff members.
- Policy SC.CM.08, Care Management Member Satisfaction Survey, states survey results are "reported to the appropriate committee(s)" at least annually but does not define the specific committee to which results are reported. Onsite discussion revealed the results are reported to the QIC.

Quality Improvement Plan

- Revise the Provider Manual and the ATC website to use the term "adverse benefit determination" instead of "action".
- Update the ATC website to include the complete definition of an adverse benefit determination as specified in the *SCDHHS Contract*.
- Update the ATC website to provide the correct form for members to appoint a representative.

Recommendations

- Revise Policy CC.PHAR.08 to clarify the process and timeframe for a determination when necessary/requested information is not received.
- Update Policy CC.PHAR.08 to specify the timeframe for sending a denial notification.
- Revise Policy SC.PHAR.07 to address the requirement that members can obtain specialty pharmaceuticals from a local pharmacy when immediate access to the medication is necessary. Refer to the *SCDHHS Contract, Section 4.2.21.4.*
- Ensure additional clinical information is requested when needed to render an initial prior authorization determination.
- Ensure authorization determinations and notifications of determinations occur within the established timeframes.
- Ensure the ATC website is updated with the correct timeframe to file an appeal and correct the timeframe to file an appeal in the UM Program Description. Refer to the *SCDHHS Contract, Section 9.1.1.2.2.*
- Confirm the correct reviewer specialty is documented in appeal resolution letters.
- Clarify the information regarding PSPCE/RSPCE and Targeted Case Management in the Care Management Program Description. Refer to the *SCDHHS Contract, Sections 4.2.22* and *4.2.28.*
- Update Policy SC.CM.08 to specify the committee to which CM Member Satisfaction Surveys are reported.

F. Delegation

ATC enters into written agreements with all entities performing delegated functions. Policy CC.COMP.21, Vendor Oversight Program Description, describes the Centene vendor oversight program for national vendors. The policy includes ongoing review of national vendor agreements to ensure amendments are developed to address compliance with State and Federal contract, regulatory, legal, or NCQA requirements.

ATC's delegated entities and services are displayed in Table 9: Delegated Entities and Services.

Table 9: Delegated Entities and Services

Delegated Entities	Delegated Services
Cenpatico Behavioral Health	Behavioral Health - Utilization Management (UM); Provider Generated Complaints; Claims

Delegated Entities	Delegated Services
	Adjudication and Provider Claim Appeals; Credentialing/Recredentialing; Network Development & Maintenance; Case Management
National Imaging Associates (NIA)	Radiology - UM; Credentialing/Recredentialing; Network Development & Maintenance
Envolve People Care (EPC) (Legacy Nutur & NurseWise)	Disease Management and Nurse Hotline
Envolve Vision	Vision - Claims Adjudication; Credentialing/ Recredentialing; Network Development & Maintenance
Envolve Pharmacy	Pharmacy Benefit Management - UM; Claims Adjudication; Network Development & Maintenance
CVS Minute Clinic; AU Medical Center/Medical College of Georgia (MCG/PPG); Greenville Health Systems; Health Network Solutions (HNS); Management Network Services; Mary Black Network; MUSC – Medical University of South Carolina; Preferred Care of Aiken; St. Francis Physician Services, Inc.; University of South Carolina University Specialty Clinics.	Credentialing/Recredentialing

Onsite discussion confirmed delegated vendor, Envolve PeopleCare, is currently transitioning multiple behavioral health delegated services (Provider Relations, Network Care Management, and Call Center) back to the health plans. Transitions are expected to be completed by April 1, 2018. The credentialing process will be transitioned later in 2018.

Policy SC.COMP.14, Vendor Oversight, describes the procedures to ensure ATC has structures and mechanisms in place for monitoring vendor services and delegation of health plan functions. Credentialing delegation is addressed in Policy CC.CRED.12, Oversight of Delegation Credentialing. Attachment J of the policy addresses ATC's unique delegated credentialing requirements. CCME recommended the required queries of the SC Excluded Provider List and the Termination for Cause List be added. Attachment B addresses SC Unique requirements. However, the document is outdated stating, "Centene Corporate 2015-2016 Health Plan Unique Requirements Grid Effective 07/01/2015." Exhibit A of the policy is a sample Audit Tool 2016/2017 and it does not match the actual tool being used for 2017 annual oversight.

ATC retains accountability for delegated services and retains the right to reclaim the responsibility for the delegated functions if the delegate is not performing adequately. Delegate performance is monitored through annual approval of the delegate's programs, routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to the contract, accreditation standards, and program requirements. Oversight is reported to and monitored by various ATC committees, including the Credentialing Committee and the Quality Improvement Committee.

Evidence of annual oversight review was received for all delegated entities. Refer to the Weaknesses section for issues related to delegation oversight.

As noted in Figure 8, Delegation Findings, one standard in the Delegation section received a "Partially Met" score.

Figure 8: Delegation Findings

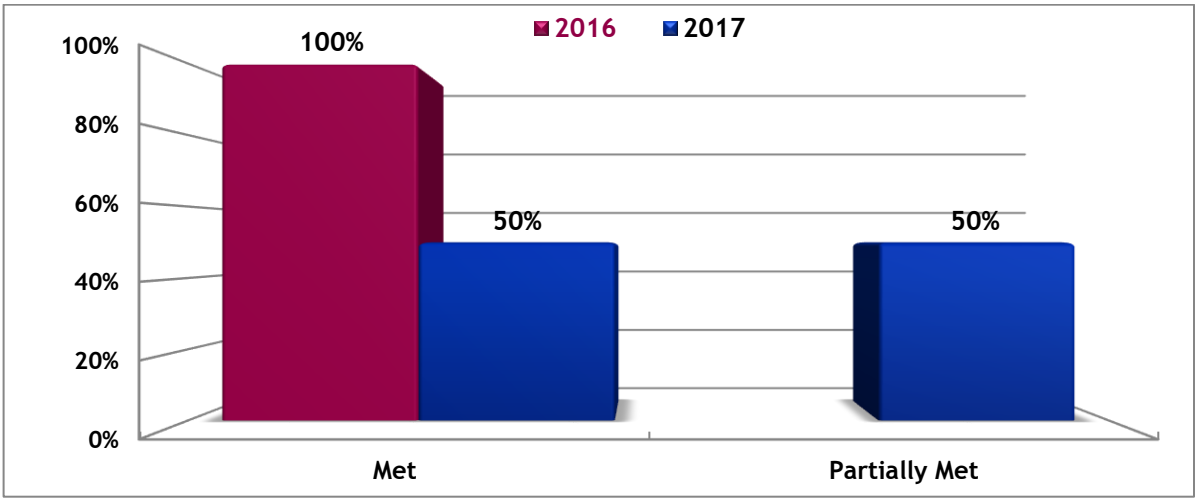


TABLE 10: Delegation Comparative Data

Section	Standard	2016 Review	2017 Review
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Weaknesses

- The following issues were identified with Policy CC.CRED.12, Oversight of Delegation Credentialing:
  - Attachment J addressed ATC's unique delegated credentialing requirements and did not include the required queries of the SC Excluded Provider List or the Termination for Cause List.
  - Attachment B addressed SC Unique requirements. However, the document was outdated with an effective date of July 1, 2015 for the 2015-2016 Health Plan Requirements.
  - Exhibit A was a sample Audit Tool 2016/2017 and it did not match the actual tool being used for 2017 annual oversight.
- The following issues were identified in reviewing ATC's annual oversight of the delegated entities:
  - Health Network Solutions – The Initial Credentialing File Audit tool was for the state of CA, not SC. During onsite discussion, ATC indicated the audit coordinator forgot to change the state field. However, the tool may not have been the same tool used to evaluate other SC delegated credentialing entities.
  - CVS Minute Clinic – The annual oversight results letter indicated 100% compliance to the file review, credentialing policy, and procedure audit. However, it was clearly documented that ownership disclosure forms were not being collected and the Social Security Death Master File (SSDMF) was not queried. There was no evidence ATC took action to ensure these deficiencies were addressed by CVS Minute Clinic.

Quality Improvement Plan

- Update Exhibit A and Attachments B and J for Policy CC.CRED.12 to reflect current information.
- Ensure the correct Credentialing File Audit tools are used during annual oversight review for SC and ensure identified deficiencies are addressed.

G. State Mandated Services

ATC provides all core benefits required by the SCDHHS Contract.

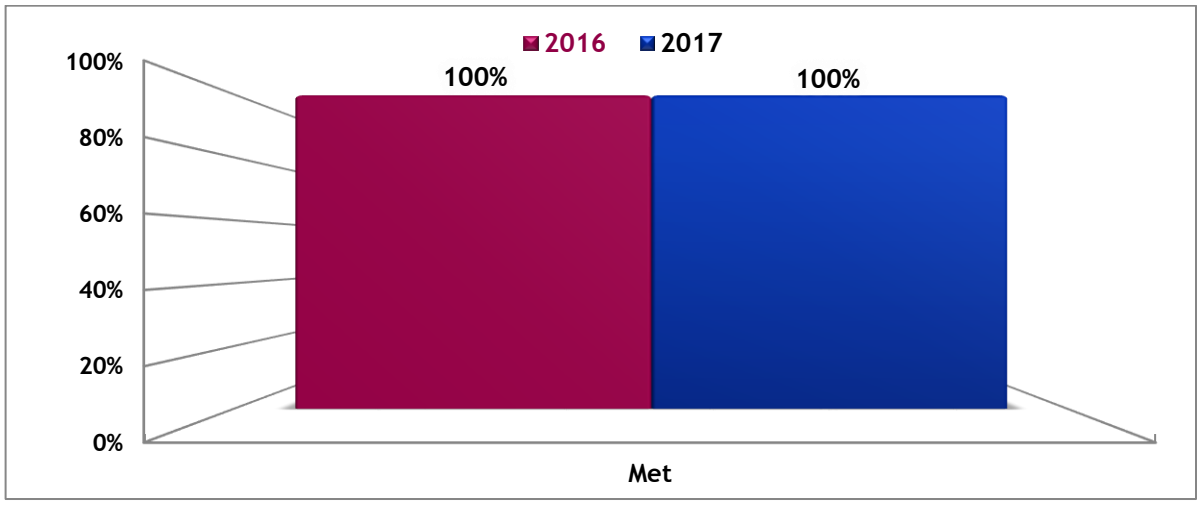
ATC educates providers about the EPSDT program, provider responsibilities, and documentation requirements via face-to-face meetings, the Provider Manual, educational materials distributed in-person and posted on the website, and new provider orientation. PCPs are given monthly reports identifying EPSDT eligible members on their panels who are newly enrolled and have not had an EPSDT visit. Providers are also given lists of

members who are out of compliance with EPSDT recommendations, including immunizations. EPSDT related care gap alerts are displayed on the Provider Portal.

ATC assesses provider compliance with the provision of recommended EPSDT services and immunizations through the annual medical record review process.

As noted in Figure 9, State Mandated Services, ATC received a score of "Met" for 100% of the standards in the State Mandated Services section.

Figure 9: State Mandated Services



ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

December 4, 2017

Mr. Paul Accardi
President
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Dear Mr. Accardi:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2017 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on March 1st and 2nd.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than December 18, 2017.

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2017

Materials Requested for Desk Review

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2016, and 2017.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from December 2016 through November 2017. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of December 2016 through November 2017.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external

review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.

    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of December 2016 through November 2017. Include any medical information and physician review documentations used in making the denial determination.

d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of December 2016 through November 2017, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at** https://egro.thecarolinascenter.org
- **should be submitted in the categories listed**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2017

Materials Requested for Onsite Review

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. The ATC Preferred Status Log (attachment to Policy SC.UM.54, Preferred Provider Designation).
3. A copy of the attachment of state specific appointment access standards for Policy EPC.QI.15, Quality Improvement Evaluation of the Accessibility of Services.
4. Please provide Attachment A & Attachment B to Policy SC.PRVR.13, Provider Orientations.
5. Please provide an example of a paper provider directory that would be given to a member upon request. We received screen shots of the online directory in the desk materials.
6. Please provide a policy, standard operating procedure, or desk procedure that explains the process for ensuring compliance to contract and federal regulation requirements for the Provider Directory.
7. Copy of Policy CQI.129, Clinical Practice Guidelines.
8. Please refer to the attached “Credentialing Document Request” and provide the documents that were not received as part of the Credentialing/Recredentialing Files.
9. Please provide the complete annual audit report for Envolve PeopleCare. We only received the Executive Summary in the desk materials.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM Validation Worksheet

Plan Name:	**Absolute Total Care**
Name of PM:	**HEDIS**
Reporting Year:	**MY 2016**
Review Performed:	**2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	
S2. Sampling	Sample treated all measures independently.	**MET**	
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	
R2. Reporting	Was the measure reported according to State specifications?	**MET**	

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PIP:	**DIABETIC EYE EXAM**
Reporting Year:	**2017**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	ATC's hybrid rate for this measure was below the NCQA quality compass 25th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addressed enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All targeted populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was stated clearly in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The indicator was a HEDIS measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	The indicator measured changes in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captured the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used HEDIS guidelines for sampling. Margin of error was reported.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used HEDIS guidelines for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used HEDIS guidelines for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Design was systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were adequate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data Analysis Plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The study documents qualified staff collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions to address barriers were documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	PIP results were presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurements were identified. Documentation regarding factors for comparability and validity were noted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Interpretation of the findings was provided.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was the same at baseline and the follow-up measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate improved from most recent measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The improvement was a result of the interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	There was statistical evidence (p-value) the improvement is true improvement from baseline.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Sustained improvement can be demonstrated after at least three remeasurements. This is not yet applicable.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	The current rate for retinal eye exam was documented in the HEDIS workbook.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	20	20

Project Score	131
Project Possible Score	131
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**ABSOLUTE TOTAL CARE**
Name of PIP:	**MEMBER SATISFACTION (NON-CLINICAL)**
Reporting Year:	**2017**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	ATC member rating of health plan was below the Book of Business average rate.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addressed enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All targeted populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was stated clearly in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in enrollee satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captured the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used the NCQA protocol for sampling.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used the NCQA protocol for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used the NCQA protocol for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Design was systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were adequate and valid.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The Data Analysis Plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	A qualified vendor collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions to address barriers were documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	PIP results were presented clearly. However, the benchmark rate for Remeasurement 2 in the results section did not match the benchmark rate in the definition of the indicator section. *Recommendation: Update the results section, p.24, to reflect the benchmark of 78.8% for Remeasurement 2, which was the benchmark stated on page 3*.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurements were identified. Documentation regarding factors for comparability and validity were noted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Interpretation of the findings was provided.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was the same at baseline and follow-up measurement.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate increased from 72.7% to 77.0%.

Component / Standard (Total Points)	Score	Comments
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement are related to interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	The increase in rate was not statistically significant. *Recommendation: Continue interventions to allow rate to increase enough to achieve statistical significance.*
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	There were three measurements, thus, it is too early to judge sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study findings were verified in CAHPS Adult report submitted by SPH Analytics.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	NA	NA
9.4	1	0
Step 10		
10.1	NA	NA
Verify	20	20

Project Score	120
Project Possible Score	126
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2017
Review Performed	2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose was documented. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC used a sample size of 1,790. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 25% (n=441 valid surveys). The target response rate according to NCQA is 40%. The target number of valid surveys (n=411) was met, although the response rate was below the NCQA target rate. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17* *Recommendation: Continue to work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and auditable approach to the implementation and analysis of the surveys. •Morpace provides a full report of process and results that meet the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 25%. The target response rate according to NCQA is 40%, thus, caution should be used when generalizing the results of the population.
7.4	What conclusions are drawn from the survey data?	There was not an internal report on the most recent 2017 CAHPS surveys. A workgroup has been formed, although the desk materials did not contain any documentation of the conclusions that have been drawn from the survey data and Morpace report. *Recommendation: Provide documentation of analysis of 2017 CAHPS results.*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *ATC 2016 Medicaid QI Eval*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *Absolute Total Care_CAHPS_Adult_Final_RY17*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS CHILD 5.0H**
Validation Period	2017
Review Performed	2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *Absolute Total Care CAHPS Child Final RY17*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *Absolute Total Care CAHPS Child Final RY17*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *Absolute Total Care CAHPS Child Final RY17*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *Absolute Total Care CAHPS Child Final RY17*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *Absolute Total Care CAHPS Child Final RY17*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *Absolute Total Care CAHPS Child Final RY17*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *Absolute Total Care CAHPS Child Final RY17*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Absolute Total Care CAHPS Child Final RY17*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,650 according to NCQA. ATC had a sample size of 2,542. Documentation: *Absolute Total Care CAHPS Child Final RY17*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *Absolute Total Care CAHPS Child Final RY17*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *Absolute Total Care CAHPS Child Final RY17*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 22% (n=567 valid surveys). The target response rate according to NCQA is 40%. The target number of valid surveys (n=411) was met, although the response rate was below the NCQA target rate. Documentation: *Absolute Total Care CAHPS Child Final RY17* *Recommendation: Continue to work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that covers the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *Absolute Total Care CAHPS Child Final RY17*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Absolute Total Care CAHPS Child Final RY17*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *Absolute Total Care CAHPS Child Final RY17*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *Absolute Total Care CAHPS Child Final RY17*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *Absolute Total Care CAHPS Child Final RY17*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *Absolute Total Care CAHPS Child Final RY17*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and auditable approach to the implementation and analysis of the surveys. •As a vendor, Morpace provides a full report of process and results that meet the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 22%. The target response rate according to NCQA is 40%, hence, use caution when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	There was no internal report on the most recent 2017 CAHPS surveys. A workgroup has been formed, although the desk materials did not contain any documentation of the conclusions that have been drawn from the survey data and Morpace report. *Recommendation: Provide documentation of analysis of 2017 CAHPS results.*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the CAHPS report. Documentation: *Absolute Total Care CAHPS Child Final RY17*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *Absolute Total Care CAHPS Child Final RY17*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Absolute Total Care**
Collection Date:	**2017**

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Absolute Total Care (ATC) policies and procedures are well-organized and are consistently reviewed and updated, as appropriate. Corporate policies addressing multiple product types have footnotes or attachments addressing SC specific information. Other policies are specific to SC Medicaid. Policies are reviewed annually. All employees have access to the policies via a shared Intranet.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Paul Accardi is the Plan President and CEO responsible for ATC's day-to-day business activities. He is accountable to the Board of Directors and ATC's parent organization, Centene Corporation, located in St. Louis, Missouri.
1.2 Chief Financial Officer (CFO);	X					Stephen Moore is the Vice President of Finance.
1.3 * Contract Account Manager;	X					Tracy Roakes is the Contract Account Manager.
1.4 Information Systems personnel;						Centene's Corporate Information Technology (IT) department supports ATC.
1.4.1 Claims and Encounter Manager/ Administrator,	X					The Senior Director of Claims is Cynthia Jones.
1.4.2 Network Management Claims/ Encounter Processing Staff,	X					Data encounter submissions are managed by the Vice President of Finance and the Analyst Team.
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Vice President of Medical Management, Madonna Lumsden, oversees the Directors of Utilization Management (UM), Case Management (CM), Medical Management auditor, and appeals and grievances. The UM Program Description states the VP of Medical Management is a registered nurse with experience in utilization management activities and reports to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ATC's CFO. The VP of Medical Management, in collaboration with the Medical Director, assists with the development of the UM strategic vision in alignment with Centene Corporation and plan objectives, policies, and procedures.
1.5.1 Pharmacy Director,	X					The Senior Director of Pharmacy is Jenna Meisner and she is a registered pharmacist in South Carolina.
1.5.2 Utilization Review Staff,	X					ATC has appropriate staff performing utilization functions as demonstrated by the organizational chart.
1.5.3 *Case Management Staff,	X					The Director of Case Management is Susan Odwyer.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Vice President of Quality Improvement is Joyce McElwain. She oversees the Senior Director of Customer Service, two Quality Improvement Managers, and the Manager of Accreditation. They are supported by Clinical Nurse Liaisons, HEDIS Coordinators, Customer Care Professionals and Data Analysts.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Vice President of Network Development and Contracting is Donald Pifer. SaBrina Macon serves as the Director of the Provider Network.
1.7.1 *Provider Services Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 *Member Services Manager;	X					The Senior Director of Customer Service is Del Allen.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Robert Thompson is a full-time Medical Director, currently licensed in South Carolina as a doctor of osteopathic medicine (DO) specializing in family practice. Dr. Thompson chairs the Credentialing Committee, and serves as a member of the Pharmacy & Therapeutics Committee, HEDIS Steering Committee, QI Committee, and ATC Vendor Oversight Committee. Dr. Cheryl Walker-McGill and recently hired, Dr. William Logan, serve as a full-time Medical Directors. The Medical Directors oversee the clinical functions of the organization. However, the organizational chart received in the desk materials did not include all Medical Directors employed by ATC. *Recommendation: Update the organizational chart to reflect all Medical Directors and their reporting structure.*
1.10 *Compliance Officer;	X					ATC's Vice President of Compliance is Talvin Herbert and he also serves as the privacy officer.
1.10.1 Program Integrity Coordinator;	X					The Program Integrity Coordinator is Timisha Birk.
1.10.2 Compliance /Program Integrity Staff;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 * Interagency Liaison;	X					The Vice President of Compliance coordinates with various agencies with the support of compliance, medical management, and case management staff.
1.12 Legal Staff;	X					The legal staff in Centene support this contract requirement.
1.13 Board Certified Psychiatrist	X					Dr. Michael Bojkovic is a Board-Certified Psychiatrist licensed in South Carolina.
1.14 Post-payment Review Staff.	X					Centene sends qualified post-payment review staff to SC to conduct onsite post payment reviews, as needed.
2. Operational relationships of MCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					The included ISCA documentation states claims are monitored for timeliness and accuracy. ATC meets the requirements and surpasses the MCO contract requirements. ATC's expected internal turn-around time is: •90.0% of clean claims processed within 30 days, •100% of all claims processed within 90 days. Actual performance results as of June 2017 exceeded those goals:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•99.9% of clean claims were processed within 30 days •100% of clean claims were processed within 90 days. The information provided showed detailed updates and improvements to their systems.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Absolute Total Care's documentation states their systems accept, handle, and generate HIPAA-compliant electronic transactions.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Absolute Total Care utilizes Amisys Advanced as its primary claims system. Documentation shows they are able to collect enrollment data and perform demographic monitoring. The documentation reflects ATC meets the requirements for updating enrollment databases, '834' transactions, and the ability to initiate a CAP, when necessary. The MCO affirms all transactions are HIPAA-compliant. ATC also attests they can identify unique members throughout their systems and that they monitor its systems for duplicate members. If a duplicate ID is found, the member's ID is merged with the duplicate medical IDs. All membership history is retained.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					According to the information provided by ATC, they provide HEDIS reports and other state-required data. Based on the materials submitted, the Plan is capable of reporting on claims, encounters, membership, enrollment and provider data. The task of auditing the MCO's database team and verifying the records reported is performed by KPMG, LLC. KPMG found the exception report for Oregon from two selected months was not configured to identify

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						all relevant errors and the Medicare exception report was not configured as a cumulative report for all errors. ATC corrected both reports and remediation testing found no exceptions.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ATC's policies and procedures for data security are comprehensive and indicate the MCO is capable of satisfying the access requirements of the contract. Additionally, ATC provided a recent audit report from KGMP, LLC which included a thorough examination of ATC's data security capabilities. The audit measured ATC's systems against 67 different objectives. ATC satisfied 59 of the objectives without exception, and has taken the appropriate steps to address, remediate, and re-test the 8 areas where exceptions were found.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					ATC's policies and procedures for IT security and access management are thorough and indicate the MCO is capable of satisfying the access requirements of the contract. Additionally, ATC provided a recent audit report from KGMP, LLC which included a thorough examination of ATC's IT security and access management capabilities. The audit measured ATC's systems against 67 different objectives. ATC satisfied 59 of the objectives without exception, and has taken the appropriate steps to address, remediate, and re-test the 8 areas where exceptions were found.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					The MCO's documentation shows detailed disaster recovery and business continuity plans. A DR test of ATC's telecommunications system was performed in June 2017, followed by a DR test of their data center in September 2017. ATC states all systems passed the tests. When audited by KGMP, it was found that one server was not configured to be replicated off-site. However, the configurations have been updated such that all in-scope servers have replicated off-site backups. As part of ongoing systems improvement, systems deployment checklists should be used and reviewed to ensure hosts comply with organizational and contract standards.
I D. Compliance/Program Integrity						
1. The MCO has written policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					Multiple policies, the Compliance Plan and the Fraud, Waste and Abuse Plan address federal and *SCDHHS Contract* requirements for detecting and preventing fraud, waste, and abuse. ATC's President/CEO has the ultimate responsibility for all Fraud, Waste, and Abuse (FWA) activities and procedures. The President delegates daily oversight of the plan to ATC's VP of Compliance. Centene's Director of the Special Investigations Unit (SIU) has a dotted line to each health plan and oversees a staff dedicated to detecting, preventing, and recovering potential FWA payments. The SIU staff also has the responsibility of supporting the health plans with their individual FWA plan and Federal/State requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Written policies, training plans, and/or the Compliance Plan includes employee and subcontractor training.	X					Policy CC.COMP.10, Annual Compliance Training, states compliance trainings will be distributed through the Company's online Learning Management System for accurate and proper reporting. All persons considered part of the workforce will be trained upon hire and then, at least, annually. This training may include but is not limited to: •Compliance: Health Insurance Portability and Accountability Act (HIPAA) •Compliance: Business Ethics and Conduct Policy (BECP) •Compliance: Fraud Waste and Abuse (FWA) Onsite discussion confirmed additional training is conducted locally including HIPAA desk audits.
3. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee reports to the ATC Board of Directors committee. The Compliance Committee is chaired by the Vice President of Compliance and additional members include ATC's President/CEO, Vice President of Medical Management, Vice President of Finance, and Vice President of Contracting, Network & Provider Relations. The committee meets at least quarterly, or more if needed, and a quorum is met with three voting members in attendance.
4. The MCO has policies and procedures in place that define the processes used to conduct post payment audits and recovery activities for fraud, waste, and abuse activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies and procedures that define how investigations of all reported incidents are conducted.	X					The Policy CC.COMP.16, Fraud, Waste and Abuse Plan defines the Prepayment Review/Investigation process.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Confidentiality and Protected Health Information (PHI) are addressed in numerous policies addressing areas such as HIPAA, individual rights to PHI, authorization for the use and disclosure of PHI, abuse and neglect reporting, among others. Members receive the Notice of Privacy Practices in the Member Handbook and are informed annually in member newsletters of their right to request a copy by calling Member Services.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, establishes standards for conducting the functions of practitioner selection and retention. Additional policies address various credentialing/ recredentialing activities. The following issues were identified: •Footnote 37 in Policy CC.CRED.01 references Policy SC.CRED.13 which is no longer an active policy. •Footnote 42 and Attachment J reference the SC Excluded Provider Listing. However, they do not reference the Termination for Cause List as required by the *SCDHHS Policy and Procedure (P&P) Guide, Sections 11.1 and 11.2.* *Quality Improvement Plan: Update Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to correct Footnote 37, update Footnote 42, and update Attachment J to reflect the Termination for Cause List as a query item.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Credentialing Committee is chaired by Medical Director Dr. Robert Thompson. Additional voting members include Medical Director Dr. Cheryl Walker-McGill and three network providers with the specialties of pediatrics and surgery. Onsite discussion confirmed that a behavioral health representative was recently added to the committee. Policy CC.CRED.03, Credentialing Committee, outlines the structure, protocols, and peer-review process used by the Credentialing Department and ATC to make recommendations regarding credentialing decisions. The committee meets monthly and onsite discussion confirmed the quorum

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is met with 2/3 of the voting members in attendance. It was noted that the 2017 QI Program Description states the quorum is a minimum of three voting members. *Recommendation: Update the 2017 QI Program Description to reflect the quorum for the Credentialing Committee is met with 2/3 of voting members in attendance.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.						Credentialing files were organized and, for the most part, contained appropriate documentation. Any issues are discussed below.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;			X			Reviewed credentialing files did not contain evidence the Termination for Cause List was queried. During onsite discussion, ATC was not aware of the query requirement. All ATC performed credentialing files reviewed contained evidence of query of the SC Excluded Providers List. Cenpatico files contained a search for OIG Compliance NOW indicating searches completed for South Carolina State Exclusions. However, it could not

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be determined which lists were queried. The Cenpatico Credentialing Checklist did not specify the SC Excluded Providers List or the Terminated for Cause List as document review items even though other queries completed by Compliance NOW were listed, such as OIG and SAM. *Quality Improvement Plan: Credentialing files should contain evidence of query of the Termination for Cause List. The Cenpatico Credentialing Checklist should be updated to document the required SC Medicaid queries: SC Excluded Providers List and the Termination for Cause List.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);		X				The ATC credentialing files reviewed contained appropriate documentation. The Cenpatico licensed professional counselors (LPC) behavioral health credentialing files did not contain proof of query of the SSDMF. During onsite discussion, ATC indicated the search is included during all OIG Compliance NOW, LLC searches performed by Aperture. However, the OIGCN Database Sources document indicated it required additional fees and processing, and the SSDMF was not listed as a document verified on the Cenpatico Credentialing Checklist. *Quality Improvement Plan: Ensure proof of query of the SSDMF is included in each Cenpatico credentialing*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						file. The Cenpatico Credentialing Checklist should be updated to document the required SSDMF query.
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					The ATC credentialing files reviewed contained appropriate documentation. Cenpatico credentialing LPC files did not address hospital admitting arrangements. Onside discussion confirmed Cenpatico does not pursue hospital admitting arrangements for behavioral health providers; however, admitting arrangements should be addressed for all providers. *Recommendation: Regarding the Cenpatico file review, ensure hospital admitting arrangements are addressed for all providers during the credentialing process.*
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed below.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;			X			Reviewed recredentialing files did not contain evidence the Termination for Cause List was queried. During onsite discussion, ATC was not aware of the query requirement. All ATC performed credentialing files reviewed contained evidence of query of the SC Excluded Providers List. Cenpatico files contained a search for OIG Compliance NOW indicating searches completed for South Carolina State Exclusions. However, it could not be determined which lists were queried. The Cenpatico Checklist did not specify the SC Excluded Providers List or the Terminated for Cause List as document review items, even though other queries completed by Compliance NOW were listed, such as OIG and SAM. *Quality Improvement Plan: Recredentialing files should contain evidence of query of the Termination for Cause List. The Cenpatico Credentialing Checklist should be updated to document the required SC Medicaid queries SC Excluded Providers List and the Termination for Cause List.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);		X				The ATC recredentialing files reviewed contained appropriate documentation. The Cenpatico LPC behavioral health recredentialing files did not contain proof of query of the SSDMF. During onsite discussion, ATC indicated the search is included during all OIG Compliance NOW, LLC searches performed by Aperture. However, the OIGCN Database Sources document indicated it required additional fees and processing, and the SSDMF was not listed as a document verified on the Cenpatico Credentialing Checklist. *Quality Improvement Plan: Ensure proof of query of the SSDMF is included in each recredentialing file.*
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					The ATC recredentialing files reviewed contain appropriate documentation. Cenpatico recredentialing LPC files did not address hospital admitting arrangements. Onsite discussion confirmed Cenpatico does not pursue hospital admitting arrangements for behavioral health providers; however, admitting arrangements should be addressed for all providers. *Recommendation: Regarding the Cenpatico file review, ensure hospital admitting arrangements are addressed for all providers during the recredentialing process.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, defines the recredentialing process and ATC considers provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization. Onsite discussion confirmed the credentialing designee gathers applicable performance data from the QI Department designee for inclusion in the recredentialing review. Physician profiling or provider report cards consist of a one-page scorecard giving physicians information on specific HEDIS measures with comparison of the practice to ATC's overall health plan score.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy SC.QI.18, Clinical Quality of Care Investigation, addresses the procedures for investigation and review of potential quality of care cases. Additional policies such as SC.CRED.07, Practitioner Disciplinary Action and Reporting, and SC.CRED.08, Practitioner Appeal Hearing Process, define the process for disciplinary action and appeal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.			X			Policy SC.CRED.05, Organizational Assessment and Reassessment, defines the credentialing/ recredentialing procedures for healthcare delivery organizations. Attachment M specifies the SC Excluded Providers Listing as a required query but does not address the requirement for the Termination for Cause List. The organizational provider credentialing/recredentialing file review showed appropriate documentation except they did not reflect queries of the Termination for Cause List. *Quality Improvement Plan: Update Policy SC.CRED.05, Organizational Assessment and Reassessment, Attachment M, to include the Termination for Cause List as a required query.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, defines the process for ongoing monitoring for practitioner sanctions, exclusions, complaints, and quality issues between recredentialing cycles. ATC's QI Department continually monitors complaints received against practitioners. Ongoing monitoring performed by the Credentialing Department on a monthly basis includes Medicare/ Medicaid-specific exclusions or NPDB reports, Office of Inspector General (OIG), System for Award Management (SAM), and SC Excluded Providers List. Opt-Out reports are reviewed quarterly. However, the policy (including Attachment J) does not address the monitoring of the Termination for Cause List or the SSDMF that is required in the *SCDHHS Contract, Section 11.2.11 and the SCDHHS P&P Guide, Section 11.1 and 11.2.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, and Attachment J to address the process of monitoring the Termination for Cause List and the SSDMF on a monthly basis.
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability, defines the measurement guidelines for assessing the availability of network providers. PCPs are assessed within 30 miles for family and general practitioners, internal medicine, and pediatrics. However, the SCDHHS Policy and Procedure Guide, Section 6.2, addresses drive time standards not mentioned in the policy for PCPs. Policy SC.CONT.02, Network Adequacy, defines the measurable standards for Medicaid PCPs as within 30 miles. However, the drive time standards are not mentioned in the policy. The GeoAccess reports received in the desk materials reflected the appropriate provider standard measurement for mileage and drive time. *Recommendation: Update Policies SC.QI.04 and SC.CONT.02 to reflect the drive time standards for*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						measuring PCP network availability.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability, defines the mileage requirements for specialists as one within 50 miles for various specialty types. However, the SCDHHS Policy and Procedure Guide, Section 6.2, addresses drive time standards not mentioned in the policy for specialists. Policy SC.CONT.02, Network Adequacy, defines the measurable standards for Medicaid Specialists as within 50 miles, and for Medicaid Hospitals as within 50 miles. However, the required drive time standards are not mentioned in the policy. The GeoAccess reports received in the desk materials reflected the appropriate provider standard measurement for mileage and drive time. Per onsite discussion, ATC is in the process of migrating network analysis for behavioral health from Cenpatico back to the health plan. *Recommendation: Update Policies SC.QI.04 and SC.CONT.02 to reflect the drive time standards for measuring network availability for specialists and hospitals.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Network adequacy is analyzed on a bi-annual basis by running GeoAccess reports for all contracted PCPs, specialists, key ancillary services, and hospitals as defined in Policy SC.CONT.02, Network Adequacy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Analysis reports are submitted to SCDHHS on a bi-annual basis as prescribed by the *SCDHHS Contract*. Policy SC.QI.04, Quality Improvement Evaluation of Practitioner's Availability, also details the process for annual assessment of network adequacy.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The 2017 Cultural Competency Medicaid Plan is listed on the ATC website and cultural competency information is included in the Provider Manual. Policy SC.QI.26, Cultural Competency Plan, defines the procedure for establishing a comprehensive linguistic and cultural competency plan for ATC to meet the needs of its members. The CCP is updated on an annual basis. Policy SC.QI.04, Quality Improvement Evaluation of Practitioners Availability, details the procedure for assessing the cultural, ethnic, racial, and linguistic needs of its members. annually. ATC works to adjust the availability of practitioners within its network, if necessary.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					ATC's online searchable Provider Directory is detailed, user friendly, and addresses contract requirements. The online Provider Directory is updated daily and paper copies are printed by Customer Service Representative upon Member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						request. The ATC Evaluation of Accuracy of Online Provider Directory 2017 report details a study conducted to ensure members have up-to date information on how to contact network providers. A random sample of 1,377 providers was selected with data collected by phone surveys administered by Provider Network staff or an online survey. Results showed 3 out of the 5 directory parameters met the designated performance goal of 100%. The lowest performing parameters were “accepting new patients” (96%) and office phone numbers (70%). Actions included provider education on submitting updates to the health plan.
3.Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy SC.QI.05, Evaluation of the Accessibility of Services, defines the mechanism utilized to monitor member access to primary care services, behavioral health services, high volume/high impact specialists and member services. Annually, the Quality Improvement department analyzes appointment accessibility including routine, urgent, and after-hours care against the standards it has defined. ATC conducted an appointment availability study in 2017 with results being reported in the 2017 QI Program Evaluation. Overall results appear to show pass rates ranging from 84% - 100% for the various categories. Immediate emergent or emergency visits scored the lowest at 84% with barriers such as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider lack of knowledge of the standards was identified. Network-wide education regarding the appointment accessibility standards was addressed as an opportunity. Results of the 2017 After Hours Survey showed a pass rate of 86% which was consistent with the 2016 study. Onsite discussion confirmed ATC representatives meet with noncompliant providers, give them time to correct the deficiencies, and then re-audit activities to ensure compliance.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the annual EQR process for ATC, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,988 unique PCPs were found. A sample of 300 providers were randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the contracted providers. Results of the Telephonic Provider Access Study demonstrated calls were successfully answered 51% (143 out of 278) of the time when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 43%, this year had a statistically significant increase in successful calls (p=.04). For calls not answered successfully (n=135 calls), 53

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(39%) were unsuccessful because the provider was not at that office or phone number listed. Of the 143 successful calls, 122 (85%) of the providers indicated they accept ATC, and one (<1%) indicated this occurred only under certain conditions. Of the 122 accepting ATC, 85 (70%) responded they are accepting new Medicaid patients. Regarding a screening process for new patients, 53 (52%) of the 102 providers responding to the item indicated an application or prescreen was necessary. Of those 53, 10 (19%) indicated an application must be filled out, whereas 11 (21%) required a review of medical records before accepting a new patient, and 10 (10%) required both. When the office was asked about the next available routine appointment, 64 (64%) of the 100 responses met contract requirements.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy SC.PRVR.13, Provider Orientations, defines the procedures for ensuring provider orientations are conducted for all newly contracted PCPs, specialists, hospitals, and/or ancillary providers. The orientations are conducted within 30 business days of becoming active with ATC. Training is offered to the providers and all staff including a sign-in sheet for recording attendees who receive training. Providers also sign an attestation verifying all staff not attending the orientation session will be provided the orientation information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual is detailed and contains sufficient information for providers to navigate the plan.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Policy SC.PRVR.14, Provider Visit Schedule/Ongoing Education, defines the procedure for establishing regularly scheduled agenda-driven face-to-face visits and providing on-going education to providers. Network Relations Specialists establish regularly scheduled visits no less than once per quarter for in-network PCPs. High volume in-network specialists receive a minimum of one face-to-face visit bi-annually. Facilities (hospitals) are encouraged to participate in a minimum of one Joint Operations meeting (JOC) per quarter. Ancillary provider visits are conducted as necessary. Provider trainings sessions are conducted in at least four regional locations throughout the state once a year via webinar or face-to-face sessions. Providers also receive information throughout the year via provider newsletters, bulletins, fax blasts, and the website.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC.QI.08, Clinical & Preventive Practice Guidelines, defines the process by which ATC adopts, develops, and distributes clinical and preventative guidelines (CPG) for the provision of acute, chronic, and behavioral health services relevant to the populations served. The guidelines are presented to the QIC for review, approval, and adoption. The guidelines are reviewed at least every two years, upon changes, or significant new scientific evidence.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					A listing of adopted CPG's is maintained in the Provider Manual with a notation the links and/or full guidelines are available on ATC's website or by hard copy upon request. Additional mechanisms to notify and distribute guidelines may include, but are not limited to, new practitioner orientation materials, provider and member newsletters, Member Handbook, special mailings, or fax blast.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					ATC has adopted several behavioral health practice guidelines such as ADHD Treatment Guidelines, Bipolar Disorder, and Major Depressive Disorder. It was noted there does not appear to practice guidelines regarding substance abuse. CCME suggested considering the adoption of guidelines to address substance abuse. Onsite discussion confirmed ATC is in the process of migrating the behavioral health services from Cenpatico back to the health plan. *Recommendation: Consider adopting practice guidelines to address substance abuse.*
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are	X					Policy SC.QI.08, Clinical & Preventive Practice Guidelines, defines the process by which ATC adopts, develops, and distributes clinical and preventative guidelines (CPG) for the provision of acute, chronic, and behavioral health services relevant to the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.						populations served. The guidelines are presented to the QIC for review, approval, and adoption. The guidelines are reviewed at least every two years, upon changes, or significant new scientific evidence.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy SC.QI.09, Continuity & Coordination Member Care, defines the procedure for detecting problems and providing continuous and appropriate care for members, and to strengthen coordination between all elements of the medical delivery system. At least annually, ATC collects data to assess, identify, and improve coordination of medical care. Policy SC.QI.28, Continuity & Coordination Between Medical and Behavioral Health Care, defines the process to ensure behavioral health providers and medical providers are collaborating to coordinate medical and behavioral health care.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy SC.QI.13, Medical Record Review, defines the process for monitoring practitioner's medical records to ensure they are maintained in a detailed, organized manner while preserving patient confidentiality. Minimum standards for practitioner documentation are defined in the policy, the Provider Manual, and on the website.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					ATC monitors Medicaid practitioners, annually, for maintenance of medical records including medical record organization, ease of retrieval, maintenance of patient confidentiality, and compliance with contractual requirement for medical record content and documentation. The 2017 Annual Audit Report showed 66 individual practitioners with a total of 317 medical records were reviewed. All 66 practitioners received a total pass score of 80% or greater, with 46 practitioners scoring 100%. The overall score for the 2017 audit year was 95%. Since the ATC goal of 80% or greater was met, no practitioners were placed on a corrective action plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy SC.MBRS.25, Member Rights and Responsibilities, indicates new members receive a Member Handbook and new member packet describing rights and responsibilities. Members are also informed of their rights and responsibilities annually and when changes occur via newsletter or direct mailing. The Provider Manual includes member rights and responsibilities. Providers are expected to post rights and responsibilities in offices and other locations

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						visible to members.
2. Member rights include, but are not limited to, the right:	X					Member rights and responsibilities were consistently documented in Policy SC.MBRS.25, Member Rights and Responsibilities, the Member Handbook, the Provider Manual, and on the ATC website.
2.1 To be treated with respect and with due consideration for his or her dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information including:		X				Policy SC.ELIG.17, Enrollment, states new member welcome packets with ID Cards are generated through an external vendor and members should receive these packets within 14 days. Onsite discussion verified the Member Handbook is included in the welcome packet.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The benefits grid in the Member Handbook, pages 18-21, lists covered services. Members are instructed to contact Member Services if they have questions about benefits. Page 18 of the Member Handbook incorrectly states elective abortions are not covered. Refer to the *SCDHHS Contract, Section 4.2.1*, Policy SC.UM.33, Abortions, and the Provider Manual. *Quality Improvement Plan: Correct the information regarding coverage of elective abortions in the Member Handbook, page 18.*
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						Information on family planning services is found on page 19 of the Member Handbook. Additional information on out-of-network services is found throughout the Member Handbook.
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						Coverage limitations and co-payments are included in the benefits grid in the Member Handbook. Members exempt from co-payment requirements are defined on page 23 of the Member Handbook. Pharmacy co-payments and co-payment exemptions are included on page 30. Discrepancies are noted in several co-payments: •The *SCDHHS Policy and Procedure Guide, Section 7.5* lists the co-payment for Ambulatory Surgery Center as $3.30. The Member Handbook, Provider Manual, and ATC website indicate the copayment is $3.40. •The ATC website lists the co-payment for Outpatient Hospital non-emergent services as $3.40. The Member Handbook and Provider Manual do not specify a co-payment for this category of services. *Quality Improvement Plan: Correct the co-payment discrepancies in the Member Handbook, Provider Manual, and on the website.*
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook provides information on obtaining emergency services, includes definitions of urgent and emergent care, and provides examples of appropriate use of each. The handbook also provides information on obtaining emergency and routine care outside of the ATC network.
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The Member Handbook describes the Preferred Drug List (PDL) and instructs members to refer to the website or call Member Services to find network pharmacies. It provides an overview of how to obtain prescriptions and the describes the pharmacy prior authorization process. The Member Handbook defines DME and provides information on the process to obtain DME, authorization requirements, etc.
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The Member Handbook informs members of their right to "receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change" and that members will be notified in writing (including the timeframes for notification) if their provider is no longer in the ATC

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						network.
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.12 Procedures for disenrolling from the MCO;						
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Members are informed of the "Find a Provider Tool" on the website that allows them to search for providers by name, location, and/or specialty. Members are also informed they can contact Member Services for information on providers. The Detailed Search function of the Find a Provider Tool allows members to search by name, provider type, provider's gender, those accepting new patients, after hours/weekend availability, accessible to those with disabilities, NPI number, group/hospital affiliation, and languages spoken by the practitioner and/or in the office.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						The Member Handbook informs that free translation services, including sign language, are available. The language line is available 24 hours a day, seven days a week. Members are instructed to contact Member Services to obtain translation services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook contains a thorough explanation of EPSDT services and the recommended schedule of well-child visits.
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can receive assistance with executing an advance directive;						The Member Handbook contains a thorough, easily understood explanation of Advance Directives and how to implement an Advance Directive.
1.22 Information on how to report suspected fraud or abuse;						Members are informed they can report suspected fraud, waste, or abuse (FWA) to ATC or to the SCDHHS Division of Program Integrity. The Member Handbook defines fraud, provides examples, and includes reporting contact information (mailing address, the confidential ATC Fraud and Abuse

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Hotline, and email address). The Member Handbook also provides the SCDHHS FWA reporting contact information, including the mailing address, email address, and telephone number. Members are encouraged to contact Member Services if they have questions or concerns about FWA.
1.23 Additional information as required by the contract and by federal regulation;						
1.24 The MCO notifies each member, at least once per year, of their right to request a Member Handbook or Provider Directory.						Members are notified of their right to request a Member Handbook or Provider Directory quarterly via member newsletters.
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Policy SC.MBRS.12, Enrollee Notification, states members are notified of new benefits and benefit changes through member newsletters, addendums to the Member Handbook, at new member orientations, and by mailed letters. ATC makes every effort to ensure the information is distributed to the members at least 30 days before the changes are effective. Policy SC. ELIG. 14, Member Notification of a Provider Termination, indicates the Enrollment Department is responsible for notifying members of the termination of a provider from whom they are receiving treatment. “ATC will make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						seen on a regular basis by, the terminated provider."
3. Member program education materials are written in a clear and understandable manner and meet contract requirements.	X					Policy SC.COMM.19, Member Materials Readability, states member materials are evaluated using the Flesh-Kincaid readability scale to ensure reading level is no higher than 6th grade (Flesch – Kincaid 6.9). As described in Policy SC.COMM.19, Member Materials Readability, foreign language versions of marketing, advertising, and educational materials are available to members in compliance with contractual requirements. Written materials are available in alternate formats, such as large font, braille, and audio formats, for members with special needs or disabilities.
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					ATC's call center is in SC and is available from 8:00 am to 6:00 pm Monday through Friday (except State holidays) via toll-free telephone number. Outside of normal business hours, an automated line provides information on office hours, instructions for verifying eligibility, and instructions on what to do in case of an emergency. Callers may leave a voicemail for a response within 1 business day or they may speak immediately with the Nurse Advice Line.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Member requests for disenrollment for cause must be directed to SCDHHS. When notification is received from SCDHHS that a member has requested disenrollment, ATC contacts the member by mail and makes at least 3 attempts to contact the member by phone. Onsite discussion confirmed the purpose of the attempts to contact the member is to try to resolve the issues that resulted in the member's request to disenroll. ATC documents all contact efforts, including final resolution, and forwards the information to the Compliance Department and SCDHHS. The Member Handbook provides information on requesting disenrollment for cause and the process to request disenrollment.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Per Policy SC.MBRS.02, PCP Change/Selection, new members can choose a PCP at the time they select an MCO. If the member does not select a PCP, one will be assigned by ATC. Members who want to change PCPs can do so at any time by submitting a PCP Selection form available on ATC's website or by calling the Member Services Department. The Member Handbook instructs members on the various ways to request a PCP change and to contact Member Services for assistance in selecting a PCP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Page 35 of the Member Handbook provides examples of preventive health guidelines and instructs members to visit the ATC website to view the guidelines or to call Member Services for more information. The website includes active links to various preventive guidelines including immunization schedules for adults and children, recommended preventive health guidelines for adults and children, lead screening for children, influenza prevention and control, and Early and Periodic Screening, Diagnostic and Treatment. The Member Handbook informs members of programs for asthma, diabetes, and high-risk pregnancy. ATC mails flyers, postcards, etc. to encourage members to participate in recommended preventive health services. A program is in place for ExamOne to conduct screening tests in diabetic member's homes and send results to their PCP/applicable providers.
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care.	X					Per Policy SC.SSFB.01, Start Smart for Your Baby®: Perinatal Management Program Overview, pregnant members are identified in various ways, including but not limited to, state eligibility lists, the notification of pregnancy process, Impact Pro reports, claims, UM processes, inpatient census reports, the Nurse Advice Line, members, providers, hospital case managers, and community events.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Pregnant members are stratified into low, moderate, and high-risk categories to identify appropriate levels of Care Management. Members are then assessed and offered enrollment into the OB Care Management Program when appropriate. The policy provides additional details on the services and information provided to members based on stratification levels.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					ATC's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description includes program goals and objectives, provider service guidelines, information on member identification and EPSDT program outreach, incentives, and information on evaluating the EPSDT program. ATC follows the Bright Futures/AAP Periodicity Schedule. The 2016 QI Program Evaluation listed barriers to meeting the 2016 EPSDT goals, including difficulty contacting members due to outdated phone numbers and addresses, and lack of desire to complete well visits. Recommendations for 2017 to address the barriers were included.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Through the Member Connections Program, ATC provides face-to-face contact, outreach, and education to members on how to access health care and develop healthy lifestyles. Member Connections staff interact with individual members telephonically or in face-to-face sessions and participate in community events to provide general information on topics such as preventive health measures, accessing care, and parenting. The Health & Wellness section of ATC's website

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						includes information on various conditions, and additional information is sent to members via newsletters and various mailings (postcards, flyers, etc.).
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					ATC contracts with Morpace, a certified CAHPS survey vendor, to conduct the Adult and Child surveys.
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					The sample sizes for the survey were adequate and met the NCQA minimum sample size and number of valid surveys, but the response rates were below the NCQA target of 40%. *Recommendation: Continue working with Morpace to increase response rates for Adult and Child surveys. Possible interventions for increasing response rates include adding a reminder to call center scripts, maximizing the oversampling, and allowing a longer timeline for additional reminders to be sent and phone call surveys to be conducted. CCME encourages ATC to decide upon and document an internal goal to increase response rates (such as a 3% increase each year).*
1.2 The availability and accessibility of health care practitioners and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Morpace summarizes and details all results from both surveys. The analysis and implementation of interventions to improve member satisfaction is conducted by a workgroup. Documentation regarding the work group meetings and analysis was submitted after the onsite meeting.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					Results of the CAHPS Surveys are offered to providers. The most recent 2017 CAHPS results have not yet been included in a Provider Newsletter. However, the 2015 and 2016 results were included in the Winter 2017 Provider Newsletter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The CAHPS Outcome Report was presented to the QIC on 08/29/2017.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC.UM.11, Member Grievances, defines ATC's processes for receiving and processing grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The term "grievance" is appropriately defined in Policy SC.UM.11, Member Grievances, the Member Handbook, the Provider Manual, and on the ATC website.
1.2 The procedure for filing and handling a grievance;		X				The *SCDHHS Contract, Section 9.1.1.2.1* indicates there is no limit to the time allowed to file a grievance. The Member Handbook has been updated to reflect there is no time limitation on filing a grievance and the revision is currently pending approval by SCDHHS. The ATC website has not been updated to indicate grievances can be filed at any time. However, ATC staff stated the website will be updated to reflect the change once SCDHHS approves the Member Handbook revisions. Policy SC.UM.11, Member Grievances, includes a resolution timeframe of 72 hours for clinically urgent grievances but does not define a process for receiving

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and processing clinically urgent grievances. Onsite discussion revealed NCQA requires a clinically urgent grievance process and that members can request expedited grievance resolution. The Member Handbook, Provider Manual, and ATC website contain no information regarding the availability of expedited grievance processing for clinically urgent grievances or that members may request expedited grievance processing. Policy SC.UM.11, Member Grievances, defines the timeframe to file a Second Review grievance as 30 calendar days from receipt of the initial notice of resolution. However, although the initial Grievance Resolution Letter informs of the availability of the Second Review grievance, it does not define the timeframe to request a Second Review grievance. *Quality Improvement Plan: Update Policy SC.UM.11, Member Grievances, to specify all applicable processes for receiving and processing clinically urgent (expedited) grievances. Update the Member Handbook, Provider Manual, and ATC website to include information about the availability of expedited grievance processing. Ensure the website is updated to indicate there is no limit on the time allowed to file a grievance. Update the initial Grievance Resolution Letter to specify the timeframe to request a Second Review grievance.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				Timeframes for standard grievance resolution are specified in Policy SC.UM.11, Member Grievances, the Member Handbook, the Provider Manual, and on the website. Policy SC.UM.11, Member Grievances, includes a resolution timeframe of 72 hours for clinically urgent grievances. However, the Member Handbook, Provider Manual, and ATC website do not define the timeframe for clinically urgent grievance resolution. *Quality Improvement Plan: Include the timeframe for clinically urgent grievance resolution in the Member Handbook, Provider Manual, and on the ATC website.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Documentation related to receipt of and response to grievances is maintained for no less than 10 years. Grievance logs include, at a minimum, a description of the grievance, receipt date, date of review, resolution, and date of resolution.
2. The MCO applies the grievance policy and procedure as formulated.	X					Grievance files confirmed resolutions were rendered and notice of resolution provided within the required timeframes. Appropriate staff investigate the grievances with physicians reviewing the grievances when appropriate. Issues noted in the grievance files include:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•4 files did not contain full documentation of the investigation by staff in other departments. •1 resolution letter incorrectly identified the grievance type. •1 resolution letter identified the grievance type as "other" without specifying the actual grievance type. •1 resolution letter used abbreviations the member may not understand. During discussion at the onsite visit, ATC staff confirmed the issues discussed have already been identified and action taken (including counseling/retraining staff and removing one staff member from grievance processing duties) to correct the issues. *Recommendation: Ensure grievance investigations are thoroughly documented in the grievance file. Ensure grievance resolution letters correctly identify the type of grievance and that letters do not use abbreviations.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are tracked and reported monthly to the Compliance Officer. The Quality Improvement Department reviews records of all grievances to identify trends and opportunities to improve quality of care and services. Review of QIC minutes confirmed grievance data is reported and discussed. Grievances that are potential QOC issues are referred to the QI Department by the GAC for investigation and resolution.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					ATC's *2017 Medicaid Quality Assessment and Performance Improvement Program Description* approved on August 17, 2017, outlines how the program measures and improves the care and services received by members and providers.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					This requirement is addressed in the Program Description and in Policy SC.QI.08, Clinical & Preventive Practice Guidelines. At least annually, ATC measures practitioner compliance with at least two measures for each of the four clinical guidelines. ATC measures practitioners' compliance using applicable HEDIS measures or Individual Practitioner review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					ATC's Board of Directors has ultimate authority and responsibility for the QI Program. The Board delegates these responsibilities to the Quality Improvement Committee (QIC).
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is comprised of senior management and network practitioners. Dr. Cheryl Walker-McGill, Medical Director serves as the chairman.
3. The QI Committee meets at regular quarterly intervals.	X					QIC meets no less than quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					ATC uses Inovalon, a certified software organization for calculation of HEDIS rates. The comparison from the previous to the current year revealed a strong increase in childhood immunization rates and lead

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						screening in children, and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. The measure that decreased were the Statin Adherence at 80%. Details of the validation of the performance measures may be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two projects were validated using the *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012.* They included Member Satisfaction and Retinal or Dilated Eye Exam (Clinical).
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Both projects scored in the "High Confidence" range. Details of the validation of the PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Per QI Program Description. ATC encourages practitioners to participation in ATC's Program initiatives through the Quality Improvement, Credentialing, and Peer Review Committees. This requirement is also addressed in the Provider Agreements.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					At least annually, ATC provides information, including a description of the QI Program and a report on progress in meeting program goals, to members and providers. At a minimum, the communication includes

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information about processes and outcomes as they relate to member care and services and ATC's specific data results such as HEDIS, CAHPS, and results of Performance Improvement Projects.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					ATC provided the *2016 Quality Assessment and Performance Improvement Program Evaluation*. This evaluation provides an analysis of ATC's performance and evaluates the overall effectiveness of the program.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management Program Description (2017) defines the purpose, goals, and scope of ATC's Utilization Management (UM) Program. It also defines lines of authority and oversight within the program and provides an overview of UM operations and how the UM Program integrates with other departments and programs within ATC's organization. Departmental policies have been developed to provide detailed guidance to staff for UM requirements and processes.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness requirements for UM determinations are appropriately documented in the UM Program Description, Policy SC.UM.05, Timeliness of UM Decisions and Notifications, the Member Handbook, the Provider Manual, and on the ATC website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Per Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, prior authorization requests are responded to within 24 hours when all necessary and requested information is supplied. Onsite discussion confirmed that if necessary information is not received, the request is reviewed by a medical director and the decision is rendered within the required 24 hours. The policy also states that in the event of a denial, the prescriber will be faxed notification of the adverse determination and reason for the denial. The policy does not specify the timeframe for faxing this notification. Onsite discussion confirmed the faxed notification is sent within the 24-hour determination timeframe. *Recommendation: Revise policy CC.PHAR.08 to clarify the process and timeframe for a determination when necessary/requested information is not received. Update the policy to specify the timeframe for sending the denial notification by fax.*
1.5 consideration of new technology;	X					Authorization requests are referred to a Medical Director for review when there are no medical necessity criteria, when the service is potentially experimental, or when the request is for new technology.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Policy SC.UM.54, Preferred Provider Designation, describes the requirements and criteria for a provider to receive preferred status, resulting in an exemption from prior authorization requirements, expedited prior authorization processing, or simplified documentation requirements for prior authorization. Onsite discussion confirmed that only one provider has received the designation. However, the program is inclusive of all provider specialties, and providers are recommended for the program based on working relationships, quality audits, etc. Criteria for inclusion include no grievances with cause, confirmed credential sanctions, or confirmed quality of care occurrences within the last 12 months. ATC is currently developing a more formalized program that will include review of approval/denial rates, etc. when evaluating providers for the program. Reporting of the program will be made to the UM Committee. Preferred status designation is reviewed annually and may be revoked at any time with or without cause.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The QIC reviews and approves the UM Program annually and has oversight and operating authority for UM activities and issues. The Medical Director has operational responsibility for and supports the UM Program. The Medical Director,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Vice President of Medical Management, and Director of UM are responsible for implementing the UM Program. A registered pharmacist oversees pharmacy services and a psychiatrist oversees behavioral health activities.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					ATC evaluates the UM program annually to identify areas of concern and develop recommendations to address areas of concern. The evaluation is submitted to the QIC for review, action, and approval. The 2016 UM Program evaluation includes an analysis of UM resources, metrics, and key performance indicators as well as comparison data for 2015 and 2016. Opportunities for improvement and interventions planned to address areas of concern are identified. Policy SC.UM.02, Clinical Decision Criteria and Application, indicates UM criteria are reviewed annually with participation of physician members of the QIC, and updated as appropriate. QIC meeting minutes reflected review and approval of internal medical policy statements and InterQual criteria.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Approval files confirm appropriate criteria are used for review and determination and medical information is requested when necessary.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Requirements and processes for coverage of hysterectomies, sterilizations, and abortions are defined in Policy SC.UM.33, Abortions, and Policy SC.UM.45, Sterilization and Hysterectomies.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions include prior authorization requirements for medications not listed in the preferred drug list (PDL). In addition, some medications have limitations based on age, dose, and/or maximum quantity. Step-therapy requirements are in place for some medications. The Pharmacy and Therapeutics (P&T) Committee evaluates drugs for inclusion in the PDL. Committee membership includes community-based practitioners and pharmacists.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					All medications not listed in the PDL and those which fall outside of the established age, dose, and maximum quantity limitations, or step-therapy requirements require prior authorization. Pharmacies may dispense a 5-day supply of medication while prior authorization is pending. Newly enrolled members taking a medication not on the PDL can fill the prescription for 30 calendar days without prior authorization (up to 60 calendar days for treatment of major depression, schizophrenia, bipolar disorder, major anxiety disorder, and attention-deficit/hyperactivity disorder). Policy SC.PHAR.07, Specialty Pharmacy Program, defines requirements and processes for coverage of specialty medications. Onsite discussion confirmed ATC allows members to obtain specialty pharmaceuticals from a local pharmacy when immediate access to the medication is necessary. This policy, however, does not address this requirement. *Recommendation: Revise policy SC.PHAR.07, to address the requirement that members can obtain specialty pharmaceuticals from a local pharmacy when immediate access to the medication is necessary. Refer to the SCDHHS Contract, Section 4.2.21.4.*
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy SC.UM.12, Emergency Services, appropriately addresses coverage and requirements associated with emergency and post-stabilization care. Appropriate information on emergency and post-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						stabilization care is found in the Member Handbook and Provider Manual.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Determinations were made within required timeframes for all UM files reviewed.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Most denial files reflected additional clinical information was requested when needed. However, it was unclear in two denial files whether necessary clinical information was requested. *Recommendation: Ensure additional clinical information is requested when needed to render a determination.*
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					All but one of the denial files reflected timely determinations and notifications. *Recommendation: Ensure authorization determinations and notifications of determinations*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						occur within the established timeframes.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC.UM.13, Member Appeals, addresses ATC's processes for receiving and processing member appeals of adverse benefit determinations.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Issues noted with the definitions of "adverse benefit determination" include: •The Provider Manual, page 87, and the ATC website use the term "action" instead of "adverse benefit determination." •The ATC website does not include the full definition of an adverse benefit determination. Refer to the *SCDHHS Contract, Section 9.1 (b) (vii).* During the onsite visit, ATC staff confirmed the Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals form (DHHS Form 1282) is being used. However, the website "Member Handbooks and Forms" page still provides the outdated Appointment of Authorized Representative form. Refer to the *SCDHHS Contract, Section 9.1.1.1.2.* *Quality Improvement Plan: Revise the Provider Manual and the website to use the term "adverse benefit determination" instead of "action". Update*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the website to include the complete definition of an adverse benefit determination specified in the SCDHHS Contract. Update the website to provide the correct form for members to appoint a representative.
1.2 The procedure for filing an appeal;	X					The *SCDHHS Contract, Section 9.1.1.2.2,* defines the timeframe to file an appeal as 60 calendar days from the date on the adverse benefit determination notice. The timeframe to file an appeal is appropriately documented in Policy SC.UM.13, Member Appeals, the Provider Manual, and the Initial PA Denial letter template. ATC staff provided evidence the appeal filing timeframe has already been updated in the Member Handbook, pending approval from SCDHHS. Staff further stated the website will be updated with the correct timeframe when approval of the Member Handbook is received. Page 22 of the UM Program Description incorrectly states the timeframe is 60 calendar days from receipt of the notice of adverse benefit determination. *Recommendation: Update the timeframe to file an appeal in the UM Program Description. Ensure the website is updated with the correct timeframe to file an appeal when approval of the Member Handbook is received from SCDHHS.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					Requirements and processes for continuation of benefits pending an appeal or State Fair Hearing are appropriately documented in Policy SC.UM.13, Member Appeals, and in the Member Handbook.
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal files reflected required acknowledgements, appropriate MD reviewers, and timely resolutions and notifications. One appeal resolution letter incorrectly identified the reviewing physician's specialty as radiology instead of his actual specialty of psychiatry. Onsite discussion confirmed this issue was already identified and additional training was provided to the appropriate employee. *Recommendation: Ensure the correct reviewer*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specialty is documented in appeal resolution letters.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC.UM.13, Member Appeals, indicates appeal records are maintained and reviewed by the QI Department to identify trends and opportunities to improve quality of care and service. Appeal records are retained for no less than 10 years. QIC minutes showed evidence that appeal data is reported and discussed.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					ATC has developed a Care Management Program Description for its Medicaid product, as well as policies to guide staff in the performance of Case Management (CM) functions.
2. The MCO has processes to identify members who may benefit from case management.	X					The Care Management Program Description and Policy SC.CM.02, Care Coordination/Care Management Services, define processes and methods of identifying members who may benefit from CM services. These include members with special health care needs; with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or who are frail, elderly, disabled, or at the end of life. Per the Care Management Program Description,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ImpactPro predictive modeling software is used to stratify members into high, medium, or low risk levels based on the member's measured illness burden or risk scores. The member's stratification level can be adjusted based on individual member factors, assessment findings, and clinical judgement.
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Page 15 of the UM Program Descriptions contains the header, "Preventive and Rehabilitative Services for Primary Care Enhancement (PSPCE/RSPCE) and Targeted Case Management." The information about these separate services has been combined and the terms are used interchangeably. This could result in confusion for staff members. *Recommendation: Clarify the information regarding PSPCE/RSPCE and Targeted Case Management in the Care Management Program Description. Refer to the SCDHHS Contract, Sections 4.2.22 and 4.2.28.*
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy SC.UM.41.01, Transition of Care, addresses transition of care when benefits end, when new members transition into ATC, and when a provider terminates participation in ATC's network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The MCO has a designated Transition Coordinator who meets contract requirements	X					The *SCDHHS Contract, Section 5.6.2*, requires the designation of a person with appropriate training and experience to act as the Transition Coordinator to interact with SCDHHS staff and staff from other MCOs to ensure safe and orderly transitions. Onsite discussion confirmed Christy Vann, Manager of Case Management, serves in this role.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					Policy SC.CM.08, Care Management Member Satisfaction Survey, describes processes for monitoring member satisfaction with CM services. Member Satisfaction Surveys are conducted via telephone or by mail for members who have participated in the CM Program for at least 60 days. An internal goal of 90% satisfaction has been established. The policy states results are "reported to the appropriate committee(s)" at least annually. Onsite discussion revealed the results are reported to the QIC. A review of the QIC minutes confirmed the CM Member Satisfaction Survey findings and results are reported and discussed. *Recommendation: Update Policy SC.CM.08 to specify the committee to which CM Member Satisfaction Surveys are reported.*
7. Care management and coordination activities are conducted as required.	X					CM files were thoroughly documented with appropriate care plans and follow-up/monitoring documented. One file was noted to have a discrepancy in the notes indicating the member initiated prenatal care in the third trimester and that a success for this member was that she received early

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						prenatal care. This was discussed at the onsite and ATC staff will monitor for these discrepancies and address, as appropriate, with the applicable staff member.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Policy SC.UM.01.03, Monitoring Utilization, defines ATC's processes for monitoring and analyzing relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization which may affect health care services, coordination of care, and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					ATC analyzes data on the following topics regarding utilization: •Inpatient Admissions and Readmissions •Length of Stay •Neonatal Rate •ER Utilization

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all subcontractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					ATC ensures enters written agreements with all entities performing delegated functions. Policy CC.COMP.21, Vendor Oversight Program Description, describes the Centene vendor oversight program for national vendors. This includes ongoing review of national vendor agreements to ensure amendments are developed to address compliance with State and Federal contract, regulatory, legal, or NCQA requirements. ATC delegates the following services: •Cenpatico Behavioral Health: Utilization Management (UM), Provider Generated Complaints, Claims Adjudication and Provider Claim Appeals, Credentialing/Recredentialing, Network Development & Maintenance, Case Management. •National Imaging Associates (NIA): UM, Credentialing/Recredentialing, Network Development & Maintenance. •Envolve People Care (Legacy Nutur & NurseWise): Disease Management and Nurse Hotline. •Envolve Vision: Claims Adjudication, Credentialing/ Recredentialing, Network Development & Maintenance. •Envolve Pharmacy: Pharmacy Benefit Management -

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						UM, Claims Adjudication, Network Development & Maintenance. •Credentialing Delegations: CVS Minute Clinic, AU Medical Center/Medical College of Georgia (MCG/PPG), Greenville Health Systems, Health Network Solutions (HNS), Management Network Services, Mary Black Network, MUSC – Medical University of South Carolina, Preferred Care of Aiken, St. Francis Physician Services, Inc., University of South Carolina University Specialty Clinics. Onsite discussion confirmed that delegated vendor, Envolve PeopleCare, is currently transitioning multiple behavioral health delegated services (Provider Relations, Network Care Management, and Call Center) back to the health plans. Transitions are expected to be completed by April 1, 2018. The credentialing process will be transitioned later in 2018.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Evidence of annual oversight review was received for all delegated entities. Policy SC.COMP.14, Vendor Oversight, describes the procedures to ensure ATC has structures and mechanisms in place for monitoring vendor services and delegation of health plan functions. Credentialing delegation is addressed in Policy CC.CRED.12, Oversight of Delegation Credentialing, and the following issues were identified: •Attachment J of the policy addressed ATC's unique

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						delegated credentialing requirements but did not include the required queries of the SC Excluded Provider List or the Termination for Cause List. •Attachment B addressed SC Unique requirements. However, the document was outdated stating, "Centene Corporate 2015-2016 Health Plan Unique Requirements Grid Effective 07/01/2015." •Exhibit A was a sample Audit Tool 2016/2017 and it did not match the actual tool being used for 2017 annual oversight. The following issues were identified in reviewing ATC's annual oversight of the delegated entities: •Health Network Solutions – The Initial Credentialing File Audit tool was for the state of CA and not SC. During onsite discussion, ATC indicated the audit coordinator forgot to change the state field. However, the tool was not the same tool used to evaluate other SC delegated credentialing entities. • CVS Minute Clinic – The annual oversight results letter indicated 100% compliance to the file review, credentialing policy, and procedure audit. However, it was clearly documented that ownership disclosure forms were not being collected and the SSDMF was not queried. There was no evidence ATC took action to ensure these deficiencies were addressed by CVS Minute Clinic. Quality Improvement Plan: Update Exhibit A and Attachments B and J for Policy CC.CRED.12 to reflect current information. Ensure the correct Credentialing File Audit tools are used during annual oversight review for SC and ensure identified deficiencies are addressed.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V II. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Per the ESPDT Program Description, providers are required to perform EPSDT check-ups at required intervals according to the AAP/Bright Futures recommendations. All exam components, including immunization administration, must be documented in the medical record of each EPSDT eligible member. Policy SC.QI.13, Medical Record Review, defines the process to conduct medical record documentation reviews annually for purposes of evaluating utilization review, quality management, disease specific HEDIS measures, medical claim review, and provision of EPSDT services.
1.2 performing EPSDTs/Well Child Visits.	X					PCPs are given monthly reports identifying EPSDT eligible members on their roster who are newly enrolled and have not had an EPSDT visit. Providers are also given lists of members who are out of compliance with EPSDT recommendations. EPSDT related care gap alerts are displayed on the Provider Portal. ATC conducts annual medical record reviews to determine provider compliance with the provision of EPSDT services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					